MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15367

Item#5, Film 431 12/18/70 kam

CERTIFICATE OF DEATH

15386

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
JOSEPH	W.	SAUNDERS	10	31	1970	9:40 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	CAUCASIAN	Aug. 10, 1901	69 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Wash. D.C.	USA		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hosp	Engineer Construction	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Maryland	Montgomery	Silver Sp.		3380 Chiswick Ct.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	H.	Saunders	Susie	A.	Harding

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes	WWII	220-05-0636	Mrs. Edna V. Saunders	3380 Chiswick Ct.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Tamponade	minute
DUE TO, OR AS A CONSEQUENCE OF (b)	Cardiac Rupture	5-10 minutes
DUE TO, OR AS A CONSEQUENCE OF (c)	Myocardial Infarct, Acute	4-5 days

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from Oct, 1966, to Oct 31, 1970, that (I)) (we) last saw the deceased alive an Oct 31 1970, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
James R Coleman MD					Nov. 1, 1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JAMES R COLEMAN	9241 COLUMBIA BLVD SILVER SPRING, Md. 20910

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov 3, 1970	George Washington Cem.	Hyattsville Prince George MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Warner E. Pumphrey, Inc.	8434 Ga. Ave. S.S. Md.	NOV 6 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carbon (pages 1 and 2 should be filed with the State Dept. af Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

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15368

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15387

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Hubert	B	Savage Sr.	Oct.	22	1970	4:20 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
m/w	Cau	8-17-[illegible]16	54 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Mississippi	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban Hospital	Property Manager	Landmark Realty Co.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
Maryland	Montgomery	Rockville	YES [X] NO [ ]	12201 Braxfield Court

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Walter	Earl	Savage	Ollie	Unknown	Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes	WW II	578 16 5975	Hilda L. Savage - wife	- add. same.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	50 min.
DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Myocardial Infarction	65 min
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Thrombosis – ASHD	10 yrs (ASHD)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Feb, 19 67, to 10/22/, 19 70, that (I) (~~we~~) last saw the deceased alive on 10/22/ 1970, and that in (my) (~~our~~) opinion death occurred at the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert C. Macon		[✓]	[ ]	[ ]	10/22/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Robert C. Macon	809 Viers Mill Rd, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/24/70	Parklawn Memorial Pk,	Rockville, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home 1331 Rockville Pike, Rockville, Md.	OCT 26 1970	Bettie D. Rogers

1204 VR A15 45M - 1-69

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15369

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
PAULYNE		SCHER	OCT.	21	1970	12:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
F	W	April 13,1900	70 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
New York	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Potomac Valley Nurs.Home	H.W.	

13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Wash.,D.C.				4501 Conn.Ave,NW Wash D.C.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jacob		Stein	Sarah		Shulman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address	
No			3052 Garrison St.NW.Wash	
			Mrs.Elaine Scher Zeller, Dghter.	D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA OF LUNGS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) METASTASES FROM BREAST

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 1940, 19___, to OCT 21, 1970, that (I) (we) last saw the deceased alive on OCT 14 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Herbert Abramson, M.D.		☑	☐	☐	OCT 21, 1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
HERBERT ABRAMSON M.D	1200 CONN AVE. N.W. WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/23/70	Wash. Hebrew Cong. Memorial Park	Wash.,D.C.

24. FUNERAL DIRECTOR	ADDRESS	25a. REGISTRAR	DATE	25b. REGISTRAR'S SIGNATURE
B Baumgarten & Sons	3501-14th St NW		OCT 26 1970	Bertie D. Rogers

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15370 — 15383

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Minnie	E	Schmidt	10	20	70	4:00 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
FEMALE	WHITE	2/17/01	69 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Penna.	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Wheaton	Nursing Home Randolph Hills	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Md.	Montgomery	Silver Spring		3563 S. Leisure World Blvd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Wm	Edgar		Elizabeth		Furch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	577-09-5843 A	Conrad Schmidt, 3563 South LeisureWorld, S.S. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Inanition — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Weeks

DUE TO, OR AS A CONSEQUENCE OF

(b) Cerebral Atrophy — 4 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3471

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			No.

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Oct., 19 66 to Oct 18, 19 70, that (I) (~~we~~) last saw the deceased alive on 10/18/70 19___, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Richard A. Yates M.D.		☒	☐	☐	10/20/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R. A. YATES	OLNEY, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
burial	10/23/70	Parklawn Cemetery	Rockville, Mont. Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. Glen Carter Warner E. Pumphrey, Inc.	8434 Ga. Ave., S.S., Md.	OCT 26 1970	

VR A15 (4) 45M - 1/69

3203

Items 1,5,6,8,13e,17 pcs
Film #G430 11/19/70
Item#7b,FilmG430 10/30/70 km

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15390

1. DECEASED NAME (Type or print) 15371 — First: IDA — Middle: DENELBAUM — Last: J. SCHOEN
2a. DATE OF DEATH — Month 10 Day 17 Year 70
2b. HOUR 12 50 A.M.
3. SEX: F
4. RACE: W
5. DATE OF BIRTH: 12-15-1890
6. AGE (In years last birthday) 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Russia
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☒
9. COUNTY OF DEATH: MONTGOMERY Co. Md.
10. CITY OR TOWN OF DEATH: TAKOMA PARK.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): WASH SAN. & Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD
13b. COUNTY: MONTGY.
13c. CITY OR TOWN: ROCKVILLE
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 6121 Montrose Rd.
14. FATHER'S NAME — First: MAX — Middle: FELDMAN — Last:
15. MOTHER'S MAIDEN NAME — First: CHAYA — Middle: R. — Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT: Sonia R. Woodnick Address: 11609 LeBaron Ter. SS Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): NEPHROSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 weeks
404X
DUE TO, OR AS A CONSEQUENCE OF (b): CARDIO-VASCULAR RENAL DISEASE — —
DUE TO, OR AS A CONSEQUENCE OF (c): ARTERIOSCLEROSIS — —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 10-9-, 1970, to 10-17, 1970, that (I) (~~we~~) last saw the deceased alive on 10-16 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Samuel A. Hillman — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10-17-70
22d. PHYSICIAN'S NAME (Type): SAMUEL A. Hillman
22e. ADDRESS: 8829 FLOWER AVE. S.S. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 10/18/70
23c. NAME OF CEMETERY OR CREMATORY: NATIONAL Capitol HEBREW Cem.
23d. LOCATION (City or Town) (County) (State): HILLSIDE MD.
24. FUNERAL DIRECTOR: B. DANZANSKY & SONS — ADDRESS: 3501-14 St. N.W. WASH. D.C.
25a. REC'D BY REGISTRAR — DATE: OCT 22 1970
25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/68

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FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremotian, or removol, and in any event within 72 hours after death.

VR A15ME (5)
10M · 1/69

3201

MARYLAND STATE DEPARTMENT OF HEALTH

15372

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15391

1. DECEASED-NAME (Type or Print)	First	Middle	Lost	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐	Month	Day	Year	2b. HOUR			
	Frieda	R	Schrag		10	12	1970	12:05 a M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last Birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
female	white	1 25 20	50 YRS.					10	12	19 70	12:05A M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. COUNTY OF DEATH
Ohio	United States	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montgomery	Rockville	YES ☒ NO ☐	14005 Eagle Ct. ~~XXX~~ Rockvill

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Samuel		Field'	Sarah		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Ferdinand Schrag	14005 Eagle Ct Rockville Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Insufficiency

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Desease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factary, affice building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Read M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town or county) Trenton

22b. DATE SIGNED Oct. 12, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	Oct. 14, 1970	King David Memorial Garden	Falls Church, Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Donald M. Stein Hebrew Memorial Funeral Home	232 Carroll St., N.W. Wash., D.C.	OCT 19 1970	Bittie D. Rogers

1

FOR STATE HEALTH DEPT.

15373

15392

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with fatal PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED ☒ Month	Day	Year	2b. HOUR			
Daniel	W.	Schrock	10-9		1970	A M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Male	W.	Feb 5, 1951	19 YRS.					Oct	9	1970	9 30 P M
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH						
Ohio	U.S.A		Montgomery Md.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY						
Gaithersburg	344 N. Summit Ave	Farming							
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Md.	Prince George's	Beltsville	YES ☐ NO ☐	11312 Evanstrail					
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last				
Waldo	O.	Schrock	Mary		Crossgrove				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS						
	281-50-1109	Waldo O. Schrock,	Fayette, Ohio						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Infarct Bilateral Difuse — 4339 — Approximate Interval Between Onset and Death: Sudden.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John G. Ball M.D.
EXAMINER'S NAME (Type) John G. Ball, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county) Bethesda, Md.
22b. DATE SIGNED Oct 10, 1970.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 13, 1970	Pettisville Cem.	Pettisville, Ohio

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Olin L. Molesworth, Damascus, Md.	OCT 14 1970	B. Ried. Rogers

VR A15ME (5)
10M - 1/69

7403

1

FOR STATE HEALTH DEPT.

15374

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15393

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
OSCAR	—	Seal	ESTIMATED ☒	10	17	1970	10 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month / Day / Year	2d. HOUR
MALE	White	8-12-12	58 YRS.			10 / 17 / 1970	10 32 P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
TENN	USA	DIVORCED ☒	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban	Logger.	Log

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Montgomery	Gaithersburg	YES ☐ NO ☐	221 Lee St

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ABIJAH		Seal	AMANDA JANE		RAGA

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (sister) ADDRESS
No		213-20-4360	Bessie Wilder - 221 Lee st Gaithersburg Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Insufficiency Acute — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden.

DUE TO, OR AS A CONSEQUENCE OF

(b) Cardio Vascular Disease — years.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus -

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John G. Ball M.D.

EXAMINER'S NAME (Type) John G. Ball

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED Oct 18, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-21-70	Seals Farm	Etchison Mont. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis H. Barber Laytonsville, Md. 20760	OCT 22 1970	Bettie D. Rogers

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with (in 2PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M - 1/69

070.1

1

FOR STATE HEALTH DEPT.

15375

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15394

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 5 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form DH3, Page 1.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: NETTIE	Middle: LEEDS	Last: SEIBERT	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: 10 Day: 10 Year: 1970	2b. HOUR: 1:15 P.M.			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 10-02-90	6. AGE (In years last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month: October Day: 10, Year: 1970	2d. HOUR: 1:15 P.M.		
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery County, Md.				
10. CITY OR TOWN OF DEATH: Olney,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Montgomery General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Howard	13c. CITY OR TOWN: Dayton	13d. INSIDE CITY LIMITS? YES XX NO [ ]	13e. STREET AND NUMBER: —			
14. FATHER'S NAME First: Col. Byrd	Middle:	Last: Willis	15. MOTHER'S MAIDEN NAME First: Emma	Middle: Menessa	Last: Willis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: Mr. Clyde Seibert	ADDRESS: Dayton, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Coronary Insufficiency

DUE TO, OR AS A CONSEQUENCE OF

(b): Hypertensive Cardiovascular Dis.

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4122

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Belden R. Resp M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): BELDEN R. RESP, M.D.

ADDRESS (Street, city, town, or county): Wheaton

22b. DATE SIGNED: Oct. 10, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	10-12-70	Greenhill Cemetery	Luray,		Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md.	OCT 20 1970	Bertie D. Rogers

VR A15ME (5)
10M - 1/69

1

15376

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15395

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25m-1/70

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR	
Victoria	Rose Octavia	Shaibe	October 25, 1970	4:45	A M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	27 November 1965	4 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH		
Washington D.C.	USA		Montgomery Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	The Clinical Center, NIH	Child			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
Maryland	Montgomery	Rockville	YES ☒ NO ☐	14202 Dennington Place	
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Mac		Shaibe	Mary		Berkenwald
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address		
No	--	None	Bethesda, Md. 20014 The Medical Record, The Clinical Center, NIH		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 Hours

DUE TO, OR AS A CONSEQUENCE OF (b) Leigh's Encephalomyelopathy — 4 Yrs. 11Mo.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that ☒ (this hospital) attended the deceased from October 18 19 70, to Oct, 25, 19 70, thot ☒ (we) lost saw the deceased alive an October 25 19 70, and thot in (☒) (aur) apinian death occurred on the dote and hour and from the causes stoted abave, ☒ (we) (did) (☒) view the bady after deoth.

22b. SIGNATURE Leonard Grauer MD DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED 25 October 1970

22d. PHYSICIAN'S NAME (Type) Leonard Grauer, M. D. — 22e. ADDRESS of Health, Bethesda, Md. 20014 The Clinical Center, National Institutes

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
	10/26/1970	CEDAR HILL	WASH. D.C.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
B. DANZANSKY & Sons	3501-14th St N.W. WASH. D.C.	OCT 28 1970	Bertie D. Rogers	

3201

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15377 — 15396

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Girl	Middle:	Last: Shapiro	2a. DATE OF DEATH Month: 10 Day: 3 Year: 70	2b. HOUR: 5:30 P.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 10-3-70	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS: 1 / MIN.: 30	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Co. Md.			
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Suburban Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Wheaton	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 2201 Greenery Lane		
14. FATHER'S NAME First: Albert	Middle:	Last: Shapiro	15. MOTHER'S MAIDEN NAME First: Laura	Middle:	Last: Weiler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mothers Chart	Address			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumaturety
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
777X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-3, 1970, to 10-3, 1970, that (I) (we) last saw the deceased alive on 10-3 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edward Cornfeld — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 10-3-70

22d. PHYSICIAN'S NAME (Type): Edward Cornfeld, M.D. — 22e. ADDRESS: 5415 Cedar Lane Bethesda, Md.

23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	10-5-70	Suburban Hospital	Bethesda (Monty) Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
R. C. Carter, Administrator per LR	OCT 9 1970	J Charles Judge

VR A15 (4)
25m-1/70

Items 18,22a Film 430 11/10/70 mh

MARYLAND STATE DEPARTMENT OF HEALTH

15378

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15397

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print): First DAVID Middle WINSTON Last SHAW

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Oct Day 30 Year 1970

2b. HOUR 145 P.M.

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: 6-19-40

6. AGE (In years last birthday): 30 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN

2c. DATE PRONOUNCED DEAD: Month Oct Day 30 Year 1970

2d. HOUR 150 P.M.

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY? WJ

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Hampshire West Court

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Fireman

12b. KIND OF BUSINESS OR INDUSTRY: Fire Dept

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 512 W. Montgomery Ave

14. FATHER'S NAME: First Daryl Middle W. Last Shaw

15. MOTHER'S MAIDEN NAME: First Dora Middle P. Last Patton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1060-1066

16b. SOCIAL SECURITY NO.: 215 36 7497

17. INFORMANT: Gloria Jean Shaw---same # 13 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Asphyxiation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Min.

876X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Carbon Dioxide

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR ~~A.M.~~ 145 P.M. 10/30 1970

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Went in man hole to rescue a man & overcome by gas

21d. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Private Rd

21f. LOCATION Street or R.F.D. No. Hampshire West Ct. City or Town Sil. Spg County Mont State Md

22a. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [ ]

DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): John Rogers 1919 Seminary Road Silver Spring, Md.

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 10/30/70

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11/2/70

23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery

23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home +1331 Rockville Pike, Rockville, Md. ADDRESS

25a. REC'D BY REGISTRAR: DATE NOV 5 1970

25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

VR A15ME (5) 8M-1/70

1005

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15379

15398

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Wallace; Middle: ; Last: Shears	2a. DATE OF DEATH Month: Oct. Day: 1 Year: 1970	2b. HOUR: M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 4-26-20	6. AGE (In years last birthday): 50 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wash. San. & Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: P.G.	13c. CITY OR TOWN: Takoma Park	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET AND NUMBER: 1108 Merwood Dr.			
14. FATHER'S NAME First: Oliver; Middle: ; Last: Shears	15. MOTHER'S MAIDEN NAME First: Dolly; Middle: ; Last: Powell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: yes (If yes give war or dates of service): WWII	16b. SOCIAL SECURITY NO.: 234-03-3906	17. INFORMANT: Marjorie G. Shears	Address: Same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b): viral failure
DUE TO, OR AS A CONSEQUENCE OF (c): multiple myeloma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 203X
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from 11/23/68, to 10/1/70, that (I) (we) last saw the deceased alive on 10/1/70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 10/1/70

22d. PHYSICIAN'S NAME (Type): Lewis H. Dennis — 22e. ADDRESS: 3906 BelPre Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-5-70	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln	23d. LOCATION (City or Town) (County) (State): Bladensburg, Md.	
24. FUNERAL DIRECTOR: Francis J. Collins	ADDRESS: 500 University Blvd. W., Silver Spring, Md.	25a. REC'D BY REGISTRAR DATE: OCT 6 1970	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

5400 VR A15 (4) 45M - 1/69

1

15380

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15399

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MARGARET	M.	~~Sheeley~~	10	30	70	11:10 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	3/14/06	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Lowell, Mass.	U.S.A.	WIDOWED ☒	MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	Holy Cross Hosp.	~~xxxxxxx~~ Libraian	Govt.

13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
	WASHINGTON D.C.		YES ☐ NO ☐	1309 Floral St. N.W.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Kristion		Myhr	Anne		Haavie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	015-07-5122	Raymond A. Sheeley	1309 Floral St. N.W. DC

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	2 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive heart failure	3 wks
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic heart disease	2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Anorexia nervosa

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Oct. 18, 1960, to Oct 30, 1970, that (I) (we) last saw the deceased alive on 10/30 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
James R Coleman MD		☑	☐	☐	10/30/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JAMES R. COLEMAN	9241 COLUMBIA BLVD. SILVER SPRING MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	Nov. 3 1970	Arlington National	Arlington		Virginia

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
~~xxxxx~~ Warner E. Pumphrey, Inc. S.S. Md.	8454 Ga. Ave.	NOV 6 1970	Vernon C. Randall

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15381 — 15400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Carrie	Middle: V.	Last: Sherwood	2a. DATE OF DEATH: Month 10 Day 19 Year 1970	2b. HOUR: 8:15 M
3. SEX: Female	4. RACE: Caus.	5. DATE OF BIRTH: 4/26/1884	6. AGE (In years last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.		
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): University Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spr.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 10803 East Nolcrest	
14. FATHER'S NAME First: Marceilus ~~unknown~~	Middle	Last: Duvall	15. MOTHER'S MAIDEN NAME First: Cornelia ~~unknown~~	Middle	Last: Stottlemyer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 578-09-6812	17. INFORMANT: Ralph D. Sherwood	Address: 10803 E. Nolcrest Dr. S.S		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Amputation R leg one wk ago - for gangrene

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospitol) attended the deceased from 10/14, 1970, to 10/19, 1970, that (I) (we) last saw the deceased alive an 10/19/70 1970, and thot in (my) (our) apinion death occurred on the dote and hour and from the couses stated above, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Myron L Lenkin	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	10/19/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Myron L. Lenkin	2309 Shorefield Dr. Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 22, 1970	Fairfax Cemetery	Fairfax Virginia

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
C. Glen Carter	Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.	DATE OCT 26 1970	Burton D. Rogers

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15382

CERTIFICATE OF DEATH

15401

1. DECEASED-NAME (Type or print) First: Lena Middle: Lost: Shoris

2a. DATE OF DEATH Month: 10 Day: 3 Year: 70

2b. HOUR: 11:55 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: 3/6/03

6. AGE (In years last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN

7a. BIRTHPLACE (State or foreign country): Austria Hungrey

7b. CITIZEN OF WHAT COUNTRY? U.S.A

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: own home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 10709 Georgia Ave Silver Spring

14. FATHER'S NAME First: Joseph Middle: Schnad Lost: Erbeck

15. MOTHER'S MAIDEN NAME First: Anna Middle: (Unknown) Lost:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 111-09-0959

17. INFORMANT: Mr John Travis husband Address: 10709 Georgia Ave Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b): Congestive heart failure — years
DUE TO, OR AS A CONSEQUENCE OF
(c): Massive cardiomegaly — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4119

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cardio-ventricular septal defect - auricular fibrillation

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Aug 25, 1970, to Oct 3, 1970, that (I) (we) last saw the deceased alive on Oct 2 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Philip E. Jones M.D. DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 10/3/70

22d. PHYSICIAN'S NAME (Type): Philip E. Jones MD

22e. ADDRESS: 9601 Colesville Rd Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10/7/70

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City or Town) (County) (State): Rockville, Montgomery, Maryland

24. FUNERAL DIRECTOR: C. Glen Carter

ADDRESS: Warner E. Pumphrey, Inc. 8434 Ga. Ave., Sil. Spg. Md.

25a. REC'D BY REGISTRAR DATE: OCT 9 1970

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

3902

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

15383

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15402

1. DECEASED-NAME (Type or Print) First Middle Last: THOMAS ADELBERT SHORTER, JR.

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ Month Day Year: 10-25-70

2b. HOUR: 5:30 pm

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: 4-14-16

6. AGE (In years last birthday): 54 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN

2c. DATE PRONOUNCED DEAD Month Day Year: 10-----25-70

2d. HOUR: 5:52 PM

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Takoma Park,

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wash.San.&Hosp.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: P.G.

13c. CITY OR TOWN: Lewisdale

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET AND NUMBER: 2302 Chapman Road

14. FATHER'S NAME First Middle Last: Thomas Adelbert Shorter, Sr.

15. MOTHER'S MAIDEN NAME First Middle Last: Lillian Foster

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): W.W. II

16b. SOCIAL SECURITY NO.: 218-07-3102

17. INFORMANT ADDRESS: Mrs. Margaret Shorter - Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Asphyxia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes —

911X

DUE TO, OR AS A CONSEQUENCE OF (b): Obstruction of Glottis c food — 5 Min.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. 5 25 P.M. 10-25 1970

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Choked when eating food —

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home

21f. LOCATION Street or R.F.D. No. City or Town County State: 2302 Chapman Lewisdale P.G. Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: Oct. 26, 1970.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Oct. 29. 1970

23c. NAME OF CEMETERY OR CREMATORY: Gate Of Heaven Cemetery

23d. LOCATION (City or Town) (County) (State): Silver Spring Md.

24. FUNERAL DIRECTOR ADDRESS: Takoma Funeral Home, J. A. Walters, 254 Carroll St NW DC

25a. REC'D BY REGISTRAR DATE: OCT 29 1970

25b. REGISTRAR'S SIGNATURE: Bettie J. Rogers

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) BM-1/70

5801

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15384

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15403

1. DECEASED-NAME (Type or print) First: GRANT Middle: R. Last: SICKELS	2a. DATE OF DEATH Month 10 Day 26 Year 70	2b. HOUR 5 50 P.M.	
3. SEX: MALE	4. RACE: Negro	5. DATE OF BIRTH: 4/12/09	6. AGE (In years last birthday) 61 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABORER	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER: 301 Lincoln Ave.
14. FATHER'S NAME First: Melvin Middle: T. Last: Sickels	15. MOTHER'S MAIDEN NAME First: Maggie Middle: L. Last: Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: yes (If yes give war or dates of service): Navy - WWII	16b. SOCIAL SECURITY NO.: 213-09-9050	17. INFORMANT: Wife, Dorothy Sickels Address: 220 Elizabeth Ave - Rockville, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

150X

IMMEDIATE CAUSE (a): Ca esophagus with

DUE TO, OR AS A CONSEQUENCE OF: mets to aorta mediation

(b): lives

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 10-24, 1970 to 10-26, 1970, that (I) (we) last saw the deceased alive on 10-26 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-30-70	23c. NAME OF CEMETERY OR CREMATORY: Lincoln Park Cem.	23d. LOCATION (City or Town) (County) (State): Rockville, Montg. Md.
24. FUNERAL DIRECTOR: George R. Mowden	ADDRESS: Rockville	25a. REC'D BY REGISTRAR DATE: NOV 2 1970	25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1701

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15385

15404

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: MAY	Middle:	Last: Silver	2a. DATE OF DEATH Month: 10 Day: 3 Year: 70
2b. HOUR: 845 A M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 4/5/85	6. AGE (In years last birthday): 85 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Chevy Chase	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Bethesda S.S. nursing home.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE ~~Florida~~ Md.	13b. COUNTY: MONTG-Y	13c. CITY OR TOWN: BETHESDA	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 14 NORTH DRIVE			
14. FATHER'S NAME First: Louis	Middle: Meyash	Last:	15. MOTHER'S MAIDEN NAME First: Rebecca	Middle:	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 103-12-0455	17. INFORMANT: Lea S. Berlin Address: 14 North Dr. Beth. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF (b): cerebral Vascular disease & Thumbosis — 1 mos

DUE TO, OR AS A CONSEQUENCE OF (c):

4339

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this hospital) attended the deceased from June, 1970, to 10-3, 1970, that (I) (we) last saw the deceased alive on 10-3 1970, and that in (my) (our) opinion death occurred on the dote and hour and from the causes stated obave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Herbert L Tanenbaum	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED: 10-3-70				
22d. PHYSICIAN'S NAME (Type): HERBERT L. TANENBAUM	22e. ADDRESS: 4400 Conn. Ave. N.W. Wash DC			

23a. ~~BURIAL~~, CREMATION, REMOVAL (Specify)	23b. DATE: 10/6/70	23c. NAME OF CEMETERY OR CREMATORY: Acacia Cemetery	23d. LOCATION (City or Town): Queens	(County): N.Y. (State)
24. FUNERAL DIRECTOR: B Dangerfield & Sons	ADDRESS: 3501-14th St N.W Wash D.C	25a. REC'D BY REGISTRAR DATE: OCT 7 1970	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

VR A15 (4)
45M - 1/69

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15386

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15405

1. DECEASED-NAME (Type or print) First: LECOUNT Middle: SKINNER Last:	2a. DATE OF DEATH Month 10 Day 15 Year 70	2b. HOUR 4 A M	
3. SEX: MALE	4. RACE: NEGRO	5. DATE OF BIRTH: 10-1-24	6. AGE (In years last birthday) 46 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Wash DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY Md.
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): UNIVERSITY NURS HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): INSURANCE AGENT	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Wash DC	13b. COUNTY	13c. CITY OR TOWN: Wash DC	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 1835 TAYLOR ST. N.W.			
14. FATHER'S NAME First: Chancy Middle: Lost: SKINNER	15. MOTHER'S MAIDEN NAME First: GRACE Middle: Lost: OGER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: UNKNOWN	17. INFORMANT: Mrs. Beatrice Jones Address: 1835 Taylor St Wash DC	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Broncho pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

485 X

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cardiac arrest c̄ resuscitation 2 yrs ago resulting in decerebrate state

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Myron L Lenkin	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/15/70
22d. PHYSICIAN'S NAME (Type): MYRON L. LENKIN	22e. ADDRESS: 901 Arcola Ave Wheaton Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-17-70	23c. NAME OF CEMETERY OR CREMATORY: Harmony Mem Pk
23d. LOCATION (City or Town) (County) (State): Landover Md.		
24. FUNERAL DIRECTOR: W.W. Chambers Co	ADDRESS: 1400 Chapel St NW Wash DC	25a. REC'D BY REGISTRAR DATE: OCT 19 1970
25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15387 — 15406

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremotian, or removol, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month / Day / Year
Elmer	Eli	Smith	10 / 1 / 70

2b. HOUR: 4:55 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	2/1/90	80 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH
Md.	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington Sanitarium & Hosp	Ret. Credit Mng.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Md	Prince George	Adelphi		2107 Rolander St.

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Asbury	A.	Smith	Sarah	Barker	~~Satterfield~~

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
(Yes)	WW I	578-03-2817	Mrs. William Walsh	2107 Rolander St. Adel.Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for ~~(a)~~, (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Terminal Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinoma of the lung — 6 months

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if ony, which gove rise to immediote couse (a), stating the underlying couse lost. 1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILOING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 9/1, 19 70, ta 10/1, 19 70, that (I) (~~we~~) last saw the deceased olive on 10/1 19 70, and that in (my) (~~our~~) opinion death occurred on the dote and hour and from the causes stated above, (I) (~~we~~) (did) (did not) view the body ofter deoth.

22b. SIGNATURE Hugh IREY M.D. — DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 10-1-70

22d. PHYSICIAN'S NAME (Type) Hugh IREY — 22e. ADDRESS 11161 N. H. Avenue, S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 3 1970	Rock Creek Cemetery	Washington D.C.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. Wisor Seward Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.	OCT 7 1970	J. Charles Judge

VR A15 (4) 45M - 1/69

5903

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15388

CERTIFICATE OF DEATH

15407

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Kathryn	M.	Smith	October 8 1970	7:15 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	Cauc	2/29/96	74 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Ind.	United States		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hosp.	HOUSEWIFE	AT HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Bethesda	YES ☒ NO ☐	4624 N. Chelsea Lane

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
THOMAS	—	McNAMARA	(UNKNOWN)	—	CUNNINGHAM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	—	577-05-5678B	GRANT S. SMITH,	SAME AS #13.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO, OR AS A CONSEQUENCE OF (b) 4123
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Parkinsons disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			YES

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) this hospital) attended the deceased from 10/1, 19 70, to 10/8, 19 70, that (I) (we) last saw the deceased alive on 10/8/70, 19 ___, and that in (my) (our) apinian death accurred an the date and haur and from the causes stated abave. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Myron L Lenkin					10/8/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MYRON L. LENKIN	2309 SHOREFIELD RD. Wheaton Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/12/70	GATES OF HEAVEN CEM.	SILVER SPRING, MONT., MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH GAWLER'S SONS INC. 5130 WISC. AVE., N. W. WASH., D. C. 20016	OCT 14 1970	Bertie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

15389

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15408

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type ar print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MAE	A.	Smith	10 17 70	9:45 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
F	Caucasian	2-9-93	77 YRS.		

7a. BIRTHPLACE (State ar foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Phila. Penna.	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address)	12a. USUAL OCCUPATION (Kind af wark dane during mast af warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Potomac Valley	housewife	own home

13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Md.	Montgomery	Rockville		1717 Evelyn Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
unknown			unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, ar unknawn) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	yes	Margaret Little, 1717 Evelyn Dr., Rockville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	myocardial infarction	10 min
DUE TO, OR AS A CONSEQUENCE OF (b)	Art. heart disease	20 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Canditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature af injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at wark Nat while ☐ at wark	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street ar R.F.D. No.	City ar Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from 10/26, 1965, ta 10/17, 1970, that (I) (we) last saw the deceased alive an 10/, 19 12, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated above, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
John M. Wyman	M.D.				10/17/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John M. Wyman M.D.	7801 Norfolk Ave. Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City ar Town) (County) (State)
Burial	10/20/70	Fort Lincoln Cemetery	Bladensburg, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. Glen Carter	Warnrer E. Pumphrey, Inc. 8434 Ga., Ave., S.S., Md.	OCT 22 1970	Bettie D. Rogers

VR A15 (4) 45M - 1/69

0905

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15390 — 15409

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Martha	Middle: (NMN)	Last: Smith	2a. DATE OF DEATH Month: 10	Day: 30	Year: 70	2b. HOUR: 5½ P.M.
3. SEX: F	4. RACE: Cauc.	5. DATE OF BIRTH: 5/4/22	6. AGE (In years last birthday): 48 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Tennessee	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery	Md.			
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Damascus	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 26801 Howard Chapel Dr.			
14. FATHER'S NAME First: William	Middle:	Last: Bryant	15. MOTHER'S MAIDEN NAME First: Vesta	Middle:	Last: Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: ?	17. INFORMANT: Daughter Barbara Darr	Address: 10 E. Reed St. Balto.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 d.
DUE TO, OR AS A CONSEQUENCE OF (b): Cirrhosis — yrs
DUE TO, OR AS A CONSEQUENCE OF (c): Chronic alcoholism — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5710

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 10/19/70, 19____, to 10/30/70, 19____, that (I) (we) last saw the deceased alive on 10/30/70 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jeremy V Cooke MD	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type): Jeremy V. Cooke	22e. ADDRESS: 10400 Conn Ave. Kensington Md		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11-4-70	23c. NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery	23d. LOCATION (City or Town): Buckeystown	(County) (State): Md.
24. FUNERAL DIRECTOR: Harry W. Haight	ADDRESS: Sykesville, Md.	25a. REC'D BY REGISTRAR DATE: NOV 4 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A15 (4) 25m-1/70

0200

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15391

CERTIFICATE OF DEATH

15410

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Ralph	WEIR	Smith	10	22	70	1 40 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	Caucasian	1-29-89	81 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Minn.	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Chevy Chase	Bethesda-Silver Spring Nursing Home	CHIEF, OFFICE OF WEIGHTS & MEASURES OESTS.	NAT. BUR.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Chevy Chase	YES ☒ NO ☐	7202 Oak Ridge Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Franklin	-	Smith	Harriet	Ellen	Weir

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	WW I	577-52-2238	JOHN A. OVERHOLT,	10400 Connecticut Ave, Kensington, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Emphysema, advanced. with pulmonary edema	15 yrs + 48 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardial Decompensation	
DUE TO, OR AS A CONSEQUENCE OF (c)	Emphysema.	

492X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Carcinoma of urinary bladder Anemia, secondary

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	YES ☐ NO ☒	—

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (~~this hospital~~) attended the deceased from —, 19 55, to Oct 22, 19 70, that (I) (~~we~~) last saw the deceased alive on Oct 20 19 70, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Stewart Clapp M.D.		☒	☐	☐	10-22-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Stewart Clapp M.D.	5413 W. Cedar La. Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/24/70	PARKLAWN CEM.	ROCKVILLE, MONT. CO., MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
JOSEPH GAWLER'S SONS, INC.	5130 WISC. AVE., N. W. WASH., D. C. 20016	DATE OCT 26 1970	Bettie D. Rogers

VR A15 (4) 30M REV. 1/68

5400

1-8

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15392

CERTIFICATE OF DEATH

15411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
SAMUEL		SNIDER	10 Month 3 Day 70 Year	5:14 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
M	White	Sept. 13, 1915	55 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Mo.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Chevy Chase	3401 Pauline Dr.	Realtor	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Montgy.	Chevy Chase	YES [X] NO [ ]	3401 Pauline Dr.

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Jacob	Snider		Jennie	----------	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Rob't W. Snider	9212 Cedarcrest Dr. Beth, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 months
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 2/20, 19 69, to 10/3/70, 19____, that (I) (we) last saw the deceased alive on 10/2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Richard Kaufman MD		[ ]	[X]	[ ]	10/3/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Richard Kaufman	916 19th St. N.W. Wash D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/4/70	Beth Sholom Cem	Hillside, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
B. Danzansky & Sons	3501 14th St. NW Wash. DC	OCT 7 1970	Charles Judge

VR A15 (4) 30M REV. 1/68

5200

10 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15393

CERTIFICATE OF DEATH

15412

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Herbert	H.	Solomon	10	13	1970	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	2-13-21	49 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Wash., D.C.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	U.S. Government	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Mont.	Wheaton	YES [ ] NO [ ]	3506 Olympic St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Samuel		Solomon	Rebecca		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes	577-12-3095	JoAnne C. Solomon	Same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	1 Days
DUE TO, OR AS A CONSEQUENCE OF (b)	Bacterial Endocarditis	14 Days
DUE TO, OR AS A CONSEQUENCE OF (c)		

4210
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 2/10/69 19___, to 10/13/70, that (I) ~~(we)~~ last saw the deceased alive on 10/13/70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John J. Curry M.D.		[X]	[ ]	[ ]	10/13/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John J. Curry, M.D.	9801 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-16-70	Columiba Gardens	Arlington, Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis J. Collins 500 University Blvd. W., Silver Spring, Md.	OCT 19 1970	Bertie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3402 VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15394 Item#6,FilmG429 10/22/70 km

15413

1

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Blanche	S.	SPEARS	OCT	15	70	1030 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	Caucasian	2 Jun. 1891	79 78 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Tennessee	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Naval Hospital	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
D.C.		Washington	YES ☒ NO ☐	2737 Devonshire Pl.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
David	L.	Snodgrass	Blanche		Fouche

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	578 38 7140	William Spears,	459 Argyle Dr. Alexandria, Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septicemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

0389

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I)(this hospital) attended the deceased from Sep. 18, 1970, to Oct. 15, 1970, that (I) (we) last saw the deceased alive on Oct. 15 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R W Virgilio MD		☐	☐	☒	16 Oct. 70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R. W. VIRGILIO, M.D.	Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-19-70	Arlington Natl	Arlington Arl. Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Everly-Wheatley Funeral Home 1500 Braddock Rd. Alexandria, Va.	OCT 19 1970	Beatrice D. Rogerson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper; pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AT 5 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15395

CERTIFICATE OF DEATH

15414

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CLARENCE	Z.	SPRIGGS	Oct. 26 1970	4A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	Caucasian	Sept. 13, 1880	90 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
New York	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	Attorney	Law

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
New York		Syracuse		716 Comstock Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James	--	Spriggs	Julia	--	Donahue

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	---	086-32-3534	Dr. Jas. O. Spriggs, 9903 Thornwood Rd.,	Kensington, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY EDEMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF

(b) ARTERIOSCLEROTIC HEART DISEASE — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

PNEUMONIA, ACUTE RENAL FAILURE, HIATAL HERNIA & CHRONIC GI BLEEDING

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 10/13, 1970, to 10/26, 1970, that (I) ~~(we)~~ last saw the deceased alive on 10/26 1970, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Richard H. Pollen	M.D.	☒	☐	☐	10/26/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Richard Pollen, M.D.	10400 Conn. Ave., Kensington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial/Transit	10/27/70	Oakwood Cemetery	Syracuse, New York

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH GAWLER'S SONS INC.	5130 WISC. AVE., N. W. WASH., D. C. 20016	OCT 30 1970	Burtie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15396 — 15415

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARIE	T.	STANG	10 7 70	2:20 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
FEMALE	WHITE	12/13/94	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Md	USA	NEVER MARRIED [X]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hosp.	retired	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Mont.	Gaithersbrg	YES [X] NO [ ]	401 Dogwood Dr.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joseph		Stang	Mary		Stang

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
	218-30-4172	David U. Stang. Gaithersburg	Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial infarction, recent — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9/29/70

4100

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis, right coronary artery — 9/29/70

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus · Hypertension

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from ——, 19 63, to 10/7, 19 70, that (I) (~~was~~) last saw the deceased alive on 10/7 19 70 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~visited~~) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED 10/8/70

22d. PHYSICIAN'S NAME (Type) H. C. [illegible]ZZINI — 22e. ADDRESS [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-10-70	St Rose.	Gaithersburg. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ernest C. Gartner	Gaithersburg Md	OCT 13 1970	Bessie D. Rogers

VR A15 (4-45M · IX-69)

1702

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

15397

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15416

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form DH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: William	Middle: Aloysius	Last: Staub	2a. DATE KNOWN OF ESTIMATED ☒	Month: 10-21	Day	Year: 19 70	2b. HOUR: 10:00 A.M.
3. SEX: male	4. RACE: white	5. DATE OF BIRTH: 7-6-91	6. AGE (In years last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month 10	Day 21	Year 19 70	2d. HOUR: 10:30 A.M.
7a. BIRTHPLACE (State or foreign country): Penna	7b. CITIZEN OF WHAT COUNTRY?: Amer	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.						
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San & Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Machinist Bureau Engraving	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 603 Greenbrier Dr					
14. FATHER'S NAME: First William	Middle	Last Staub	15. MOTHER'S MAIDEN NAME: First Catherine	Middle	Last Glass				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-34-2420	17. INFORMANT: wife	ADDRESS: Silver Spring Md. – Elsie A. Staub, 603 Greenbrair Dr.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Insufficiency Acute – | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden –

DUE TO, OR AS A CONSEQUENCE OF

(b): Cardio Vascular Disease – | Years –

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I taak charge of the remains described abave, held an Autapsy ☐, Inspectian ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): John G. Ball MD Bethesda, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, tawn, or caunty)

22b. DATE SIGNED: Oct 21, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/23/70	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State): Silver Spring, Mont. Md.		
24. FUNERAL DIRECTOR: C. Glen Carter	ADDRESS: Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S., Md.	25a. REC'D BY REGISTRAR DATE: OCT 26 1970	25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers		

VR A15ME (5) 8M-1/70

2900

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15398 — 15417

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

1. DECEASED-NAME (Type or print) First	CLYDE	Middle L.	Last STEADMAN
2a. DATE OF DEATH Month Day Year	October 16 1970		2b. HOUR 6 00 AM
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	June 21, 1894		
6. AGE (In years last birthday)	76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	South Carolina		
7b. CITIZEN OF WHAT COUNTRY?	USA		
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐			
9. COUNTY OF DEATH	Montgomery Md.		
10. CITY OR TOWN OF DEATH	BETHESDA		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Suburban		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Retired		
12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MD.		
13b. COUNTY	Montgomery		
13c. CITY OR TOWN	Rockville		
13d. INSIDE CITY LIMITS? YES ☒ NO ☐			
13e. STREET AND NUMBER	607 Muriel Street.		
14. FATHER'S NAME First	George H.	Middle	Last STEADMAN
15. MOTHER'S MAIDEN NAME First	Sally	Middle ANN	Last Powell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	Yes	(If yes give war or dates of service) WWII	
16b. SOCIAL SECURITY NO.	250 44 4869		
17. INFORMANT	daughter MARY B. SHAW	Address	ABOVE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
485X IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19 63, to 10-16, 19 70, that (I) (we) last saw the deceased alive on 10-15 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	D. L. Bucy	DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 10-16-70
22d. PHYSICIAN'S NAME (Type)	D. L. Bucy	22e. ADDRESS	809 Veirs Mill Rd Rockville

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County) (State)
Burial	10/19/70	Damascus Methodist Ch.	Damascus, Maryland	
24. FUNERAL DIRECTOR ADDRESS	Tyson Wheeler Funeral Home 1331 Rockville Pike, Rockville, Md.	25a. REC'D BY REGISTRAR DATE	OCT 23 1970	25b. REGISTRAR'S SIGNATURE Bettie D. Rogers

0905

MARYLAND STATE DEPARTMENT OF HEALTH

1 FOR STATE HEALTH DEPT.

15399

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15418

1. DECEASED-NAME (Type or Print) First: Jeffrey Middle: Ray Last: Stevens

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ Month 10 Day 28 Year 1970

2b. HOUR 9:00 A.M.

3. SEX: M.

4. RACE: W

5. DATE OF BIRTH: Sept 21, 1970

6. AGE (In years last birthday) YRS. IF UNDER 1 YEAR: MONTHS 1 DAYS 7 IF UNDER 24 HRS.: HOURS MIN

2c. DATE PRONOUNCED DEAD Month Oct Day 28 Year 1970

2d. HOUR 10:00 A.M.

7a. BIRTHPLACE (State or foreign country): Md.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 8711 Arliss ~~Rd~~ Street

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): None

12b. KIND OF BUSINESS OR INDUSTRY: None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET AND NUMBER: 8711 Arliss ~~XXXX~~ Street

14. FATHER'S NAME First: David Middle: Fowler Last: Stevens

15. MOTHER'S MAIDEN NAME First: Wanda Middle: Patricia Last: King

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: None

17. INFORMANT: Garnett Edwards, 1808 Albertie Drive ADDRESS: Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sudden Death in Infantcey — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

795X

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): John G. Ball MD Bethesda, Md.

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: Oct 28, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10/30/70

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City or Town) (County) (State): Rockville Mont. Maryland

24. FUNERAL DIRECTOR: C. Glen Carter C. Glen Carter ADDRESS: Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S., Md.

25a. REC'D BY REGISTRAR DATE: NOV 2 1970

25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M - 1/69

2301

1

FOR STATE HEALTH DEPT.

15400

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15419

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
ALICE	VIRGINIA	STONE	X	10-	7-	70	1:43 P

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Fe	Wht	12-16-14	55 YRS.			10-	7	1970	1:43 P

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
N. C.	USA	MARRIED X	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington San & Hosp.	Beautician	Beauty Salon

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montgomery	Takoma Park	YES X NO	7704 Blair Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Last
William		Ashburn	ALice	Schaeffer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		578-12-6359	Fenton Stone	7704 Blair Rd., Tk. Pk. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Artery Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO X

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF M.D. Belden R. Reap

EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

ADDRESS (Street and No. or R.F.D., City or Town, County) Rockville

22b. DATE SIGNED Oct. 7, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 10, 1970	Fort Lincoln Cemetery	Bladensburg Prince George MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. Glen Carter	Warner E. Pumphrey, Inc. 8434 Ga., Ave., S.S. Md.	OCT 13 1970	Burial Permit

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

FOR STATE HEALTH DEPT.

15401

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15420

1. DECEASED-NAME (Type or Print) First	Middle	Last
Georgia	Kostatinou	Stratigis

2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month 10 Day Year 19 — 2b. HOUR 9:25 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
female	white	6/10/93	77 YRS.				

2c. DATE PRONOUNCED DEAD Month 10 Day 12/70 Year 19 — 2d. HOUR 9:25 AM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. COUNTY OF DEATH
Greece	Greece	MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring, Md.	Holy Cross Hospital	housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Silver Spring	YES [X] NO [ ]	10120 Hereford Place

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Anastasios	NMI	Medes	Florence	CHAKALAKIS	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	220602356J	Son/Gus Stratigis as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma of

DUE TO, OR AS A CONSEQUENCE OF

(b) Stomach

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1519

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Belden R. Reap M.D.

EXAMINER'S NAME (Type) BELDEN R. REAP, M.D. Wheaton

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS (Street, City or Town, County)

22b. DATE SIGNED Oct. 12, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	13 OCT. 1970	WASHINGTON NATIONAL	SUITLAND MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
RINALDI FUNERAL HOME INC.	7100 GEORGIA AVE. N.W., WASHINGTON, DC 20012	OCT 14 1970	Burrid D. Rogers

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

3100 VR A15ME (5) 10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 15402 15421

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Elva	Middle: M.	Last: Swarthout	2a. DATE OF DEATH: Month 10 Day 10 Year 70
2b. HOUR: 12 P.M.			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 9-12-95	6. AGE (In years last birthday): 75 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Bookkeeper	12b. KIND OF BUSINESS OR INDUSTRY: Private
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Mont.	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 2 Walker Avenue			
14. FATHER'S NAME First: Theodore	Middle	Last: Sakers	15. MOTHER'S MAIDEN NAME First: Susie	Middle	Last: Harrison
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 577-46-6114	17. INFORMANT: daughter Nelda G. Gartner	Address: Box 637 Bally Green, VA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Retroperitoneal abscess, pelvic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1541
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma, Rectum, resected — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS DR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from Sept, 19 70, to Oct 10, 19 70, that (I) (we) last saw the deceased alive on 10/10 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert G. Brewer M.D.	DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/10/70
22d. PHYSICIAN'S NAME (Type): Robert G. BREWER	22e. ADDRESS: 8505 Old Georgetown Rd Bethesda Md.		

23a. BURIAL, CREMATION, REMOVAL: Burial	23b. DATE: 10-13-70	23c. NAME OF CEMETERY OR CREMATORY: Ivy Hill	23d. LOCATION (City or Town): Laurel	(County): Maryland (State)
24. FUNERAL DIRECTOR: Ernest C. Gartner, Gaithersburg Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: OCT 14 1970	25b. REGISTRAR'S SIGNATURE: [illegible] Reg.	

VR A15 (4) 25m-1/70

0701

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15403

15422

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (Give Page 4, Item 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: James	Middle: ALoysius	Last: Sweeney	2a. DATE KNOWN OF DEATH / ESTIMATED ☒	Month: Oct	Day: 3	Year: 1970	2b. HOUR: 10 PM			
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: Oct 29 1884	6. AGE (In years last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month Oct	Day 3	Year 1970	2d. HOUR: 10 40 PM		
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery								
10. CITY OR TOWN OF DEATH: Bethesda.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 10500 Rockville Pike	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): VICE PRESIDENT (RET) BANKING	12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 10500 Rockville Pike.							
14. FATHER'S NAME First: John	Middle	Last: Sweeney	15. MOTHER'S MAIDEN NAME First: Margret	Middle:	Last: SHELAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): None	16b. SOCIAL SECURITY NO.: 151-03-1458	17. INFORMANT: Mrs Roberta L. Hall	ADDRESS: 7200 Harvard Ave Bethesda, Md								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Broncho Pneumonia — — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF

(b): Cardio Vascular Disease — — 4124 — 4 years

DUE TO, OR AS A CONSEQUENCE OF

(c): Generalize Arterio sclerosis — — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): JOHN G. BALL

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): 9936 Old Georgetown Rd Bethesda, Md

22b. DATE SIGNED: Oct 4, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL	23b. DATE: 10/5/1970	23c. NAME OF CEMETERY OR CREMATORY: HOLY SEPULCHRE CEM.	23d. LOCATION (City or Town): TOTOWA	(County):	(State): N.J.

24. FUNERAL DIRECTOR: JOSEPH GAWLER'S SONS INC. ADDRESS: 5130 WISC. AVE. N.W. WASH. D.C. 20016

25a. REC'D BY REGISTRAR DATE: OCT 7 1970

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 10M - 1/69

1203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15404 — 15423

1. DECEASED-NAME (Type or print): First ALOYSIUS Middle LAWERENCE Last SZYMANSKI
2a. DATE OF DEATH: Month OCT Day 6 Year 1970
2b. HOUR: 0205 A.M.
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: 13 May 1922
6. AGE (In years last birthday): 48 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Wisc.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Naval Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): US Navy
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Va.
13b. COUNTY:
13c. CITY OR TOWN: Falls Church
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 6436 Spring Terrace
14. FATHER'S NAME First Francis Middle Lost Szymanski
15. MOTHER'S MAIDEN NAME First Anne Middle Lost Wielgus
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 390164368
17. INFORMANT: Mrs. Grace Szymanski Address: 6436 Spring Terr. Falls Church Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Meningioma with Intracranial Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [X] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (X) (this hospital) attended the deceased from 1 Oct, 19 70, to 6 Oct, 19 70, that (X) (we) last saw the deceased alive on 6 Oct 1970, and that in (X) (our) opinian death occurred on the dote and hour and from the couses stated above, (X) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE: R. Vernal M.D. DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 6 Oct 1970
22d. PHYSICIAN'S NAME (Type): R. VERNAL M.D.
22e. ADDRESS: Naval Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/9/70
23c. NAME OF CEMETERY OR CREMATORY: Assump. of Blessed Virgin
23d. LOCATION (City or Town) (County) (State): Mary-Pulaski, Wisconsin
24. FUNERAL DIRECTOR: Falls Church Funeral Home ADDRESS: 1102 W. Broad St. Falls Church, Va.
25a. REC'D BY REGISTRAR DATE: OCT 9 1970
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

1
FOR STATE HEALTH DEPT.

15405

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15424

1. DECEASED-NAME (Type or Print) First	Middle	Last
Clarence	W.	Tabler

2a. DATE KNOWN OF DEATH ESTIMATED ☒ Month Oct Day 13 Year 1970 — 2b. HOUR 4:00 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
M.	W	5/30/1880	90 YRS.				

2c. DATE PRONOUNCED DEAD Month Oct Day 13 Year 1970 — 2d. HOUR 6:45 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. COUNTY OF DEATH
West Va.	U.S.A	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	8700 Garfield St	Retired	Druggist

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montgomery	Bethesda	YES ☒ NO ☐	9700 Garfield. St

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Moses		Tabler	Laura	O	Tayler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		579-05-3735	Amy Young	8700 Garfield St. Beth. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Embolism. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden.

DUE TO, OR AS A CONSEQUENCE OF

(b) Massive Pulmonary Infarction. Rt-Lower-lung — 4 days

DUE TO, OR AS A CONSEQUENCE OF

(c) Phlebitis of Legs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4510

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John G. Ball M.D.

EXAMINER'S NAME (Type) John G. Ball

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Old. Georgetown Rd. Beth. Md.

22b. DATE SIGNED Oct 14, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	10-15-70	Cedar Hill Crematory	Suitland Pr. Geo. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert A. Rumphrey, P.A. Beth. Md.	OCT 19 1970	Bertie D. Rogers

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M - 1/69

4600

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15408 — 15427

1. DECEASED-NAME (Type or print): First: William; Middle: Blaine; Last: Thompson, Jr.

2a. DATE OF DEATH: Month: October; Day: 12; Year: 1970

2b. HOUR: 12:20 P.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: 22 August 1917

6. AGE (In years last birthday): 53 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN

7a. BIRTHPLACE (State or foreign country): Virginia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): The Clinical Center, NIH

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Asst. Vice President

12b. KIND OF BUSINESS OR INDUSTRY: Railroad Association

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Virginia

13b. COUNTY: Arlington

13c. CITY OR TOWN: Arlington

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 2729 South Ives Street

14. FATHER'S NAME: First: William; Middle: Blaine; Last: Thompson, Sr.

15. MOTHER'S MAIDEN NAME: First: Catherine; Middle: R.; Last: Foley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes

(If yes give war or dates of service): WWII

16b. SOCIAL SECURITY NO.: 262-22-3909

17. INFORMANT: The Medical Record — Address: The Clinical Center, NIH, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral and Cerebellar Melanoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Months

DUE TO, OR AS A CONSEQUENCE OF (b): Malignant Melanoma, right thigh — 6 Years

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

1728

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [X] NO [ ]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING [ ] CAUSE OF DEATH (If either, notify medicol examiner)

21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Yeor 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that [X] (this hospital) attended the deceased from 11 October, 19 70, to 12 Oct., 19 70, that [X] (we) last saw the deceased alive an 12 October 19 70, and that in [XX] (aur) apinian death accurred an the date and haur and fram the causes stated abave, [X] (we) (did) [XXXX] view the body after death.

22b. SIGNATURE: Lowell E. Schnipper M.D. DEGREE — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22c. DATE SIGNED: 12 October 1970

22d. PHYSICIAN'S NAME (Type): Lowell E. Schnipper, M. D.

22e. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10/15/70

23c. NAME OF CEMETERY OR CREMATORY: Oakwood Cem.

23d. LOCATION (City or Town) (County) (State): Falls Church Va.

24. FUNERAL DIRECTOR: B. L. Cook Pearson Funeral Home — ADDRESS: Falls Church Va.

25a. REC'D BY REGISTRAR DATE: OCT 16 1970

25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15406

15425

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 68. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: Francis / Frank	Middle: Hugh	Last: Thomas	2a. DATE KNOWN ☐ OF ESTI-MATED ☒ Month: oct	Day: 28	Year: 1970
2b. HOUR OF DEATH: 10 45 P M						
3. SEX: M.	4. RACE: W.	5. DATE OF BIRTH: 3-30-1914	6. AGE (In years last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month: Oct Day: 29 Year: 1970
2d. HOUR: 5 20 P M						
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.			
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 30 W. Deer Park Dr.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 30 W. Deerpark Dr		
14. FATHER'S NAME First / Middle / Last: Frank A Thomas	15. MOTHER'S MAIDEN NAME First / Middle / Last: Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): 1941-1944	16b. SOCIAL SECURITY NO.: 578-14-7146	17. INFORMANT (Name, Address): Linda Thomas (Daughter) 182 Bayside Dr. Clearwater Beach, Fla.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

955X

IMMEDIATE CAUSE (a): Gunshot Wound of Head.

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10 95 P.M. 10 28 1970	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Shot self with pistol 32 Cal.
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): apt.	21f. LOCATION Street or R.F.D. No. — City or Town: 30 W. Deerpark Dr. Gaithersburg County: Mont. State: Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John D. Ball M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: Oct 29, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 11/2/70	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State): Prince George's County, Md	
24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home	ADDRESS: 1331 Rockville Pike Rockville, Maryland	25a. REC'D BY REGISTRAR DATE: NOV 5 1970	25b. REGISTRAR'S SIGNATURE: Vernon B. Randall	

VR A15ME (5) 10M - 1/69

0205

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15407

CERTIFICATE OF DEATH

15426

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year
MARY	FRANCES	THOMAS	Oct. 24 1970

2b. HOUR: 6:00 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	FEB. 17, 1914	56 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WASH. D.C.	U.S.A.	MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	MONT. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
KENSINGTON	CARROLL HALL SANITARIUM	HOUSE WIFE	—

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
WASH. D.C.		WASHINGTON	YES ☑ NO ☐	3210 WISC. AVE. N.W.

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
ROY		COMPTON	ETHEL		DIXON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	—	MRS. Peggy SULLIVAN	10005 CARMENTA DR. POTOMAC, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral atrophy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct., 1968, to Oct. 24, 1970, that (I) (~~we~~) last saw the deceased alive an Oct 22 1970, and that in (my) (~~our~~) apinian death accurred an the date and haur and from the causes stated abave, (I) (~~we~~) (~~did~~) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Harold F. McCann	M.D.	☒	☐	☐	10-24-70.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
HAROLD F. McCANN	3355 - 16th St. N.W. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
BURIAL	Oct 27, 1970	GATE OF HEAVEN CEM	WHEATON Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John F. DeVol (DeVol Funeral Home)	WASH. D.C.	OCT 28 1970	Betty J. Rogerson

VR A15.2(A)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15409 — 15428

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Eleanor	Middle: W.	Last: THURSTON	
2a. DATE OF DEATH Month: 10 Day: 26 Year: 70	2b. HOUR: 6 15 PM		
3. SEX: Female	4. RACE: W	5. DATE OF BIRTH: 7-25-04	6. AGE (In years last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): md	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: montgomery Md.
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Holy Cross	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Florida	13b. COUNTY: LAKE	13c. CITY OR TOWN: Mt. Dora	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 261 OAK Hill DRIVE			
14. FATHER'S NAME First Middle Last: William S. White	15. MOTHER'S MAIDEN NAME First Middle Last: Mary Virginia		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ----------	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: R. Lamont Thurston - husband - same # 13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable Myocardial infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Moments
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify thot (I) (this hospitol) attended the deceased from Oct 21, 1970, to Oct 26, 1970, thot (I) (we) last saw the deceased olive on Oct 26, 1970, and thot in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 10-26-70		
22d. PHYSICIAN'S NAME (Type): ABRAHAM W. DANISH	22e. ADDRESS: 1106 SPRING ST S.S. Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/28/70	23c. NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery	23d. LOCATION (City or Town) (County) (State): Beallsville, Maryland	
24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home ADDRESS: 1331 Rockville Pike, Rockville, Md.	25a. REC'D BY REGISTRAR DATE: OCT 29 1970	25b. REGISTRAR'S SIGNATURE: Beatrice D. Rogers		

VR A15 (4) 45M - 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15410 — 15429

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	2b. HOUR
Jacob		Tierson	10-11-1970	8:20 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	Jan. 19, 1897	73 YRS.			10 — 11 — 1970	8:20 AM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Holland	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Montgomery Ave.	Retired	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
N.Y.		Sodus	YES [X] NO [ ]	12 Carlton Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Issac		Tierson	Nellie		(Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 1	095-09-2512	Suzanne Tierson (Wife)	Same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, City or Town, or county) 11502 Grandview Ave Wheaton, Md.

22b. DATE SIGNED Oct. 11, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/14/70	Lakeview Cemetery	Pultneyville, New York

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home	1331 Rockville Pike Rockville, Maryland	OCT 15 1970	Bertrid B. Rogers

Item 18 Film 430
11/13/70 mh

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15411

15430

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year
Shirley	Ann	Timms	Oct	31	1970

2b. HOUR OF DEATH: 9:30 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.
F	C	Oct. 30, 1952	18 YRS.				

2c. DATE PRONOUNCED DEAD Month: Oct Day: 31 Year: 1970

2d. HOUR: 9:32 M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. COUNTY OF DEATH
Wash, DC	US	MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Univ Nursing Home, 501 Aracadia	Student	---

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
D.C.	None	Washington	YES ☒ NO ☐	1600 Ft. David St. SE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James		Williams	Jean		Belser

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Mrs. Jean B. Timms (Mother) 1600 Ft. Davis St., S.E.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

969X

IMMEDIATE CAUSE (a) Exanimation severe — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Atrophy of cerebral hemotoma

DUE TO, OR AS A CONSEQUENCE OF

(c) Severe head trauma — 2 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
Oct. 2, 1968	Removal of left Subdural Hematoma	YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	Oct. 2 1968	Assulted

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
			Washington		DC

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) — M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: Nov 1, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11-7-1970	Harmony Memorial Park	Landover, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
MALVAN & SCHEY, INC. 424 R St., N. W. Wash., D.C.	NOV 9 1970	Vernon B. Randall

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15412 — 15431

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	Edward R. Tindell	2a. DATE OF DEATH Month / Day / Year	10 / 20 / 70	2b. HOUR	3:45 A.M.
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH	11/10/08
6. AGE (In years last birthday)	61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. COUNTY OF DEATH	MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH	Kensington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Carroll Hall Sam.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	ACCOUNTANT
12b. KIND OF BUSINESS OR INDUSTRY	ACCOUNTING				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MD.	13b. COUNTY	MONTGOMERY	13c. CITY OR TOWN	SILVER SPRING
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐	13e. STREET AND NUMBER	1730 NEW HAMSHIRE AVE		
14. FATHER'S NAME First / Middle / Last	GEORGE TINDELL	15. MOTHER'S MAIDEN NAME First / Middle / Last	CAROLINE WASSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	YES 1940-1945	16b. SOCIAL SECURITY NO.	119-12-9356	17. INFORMANT Address	MARYLOU CONLON 1730 NEW HAMSHIRE SILVER SPRING MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) — Inanition - dehydration — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying cause last.

(b) Carcinoma of the Lung — 3 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	May 1969	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	Carcinoma of the Lung
20a. AUTOPSY?	YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)			
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from March, 19 69 to Oct 20, 19 70, that (I) (we) last saw the deceased alive on October 1st 19 70 and that in (my) (our) opinion death occurred on the date and haur and from the causes stated abave, (I) (we) (did) (did not) view the bady after deoth.

22b. SIGNATURE	John T. Hagenbucher M.D.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐		22c. DATE SIGNED	10/20/70
22d. PHYSICIAN'S NAME (Type)	John T. Hagenbucher, M. D.	22e. ADDRESS	916-19th St, N.W. Washington, D.C.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	BURIAL	23b. DATE	Oct 24, 1970	23c. NAME OF CEMETERY OR CREMATORY	LAKEVIEW CEMETERY
23d. LOCATION (City or Town)	INTERLAKEN	(County)	SENECA CO.	(State)	N.Y.
24. FUNERAL DIRECTOR	W.W. CHAMBERS & CO.	ADDRESS	RIVERDALE, MD.	25a. REC'D BY REGISTRAR DATE	OCT 26 1970
25b. REGISTRAR'S SIGNATURE	B. Reid Raymond				

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15413

CERTIFICATE OF DEATH

15432

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ANNA		TOCKMAN	10	16	70	8:55AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
Female	White	11/15/96	73 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Russia	U.S.A.	MARRIED X	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD	MONTGOMERY	S S	YES X NO	9711 NASSAU LANE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Isidore		Karofsky	Unknow		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
	060-20-3877	Albert Tochman 9711 Nassau Ln., S.S.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES
4369
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
CARCINOMA SIGMOID COLON WITH PERITONEAL METASTASES

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO X	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 9-27, 19 70, to 10-16, 19 70, that (I) ~~(we)~~ last saw the deceased alive on 10-16 19 70, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
	MD	X	☐	☐	10-16-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Leonard Dietz, M.D.	111 Spring St., Sil.Spr., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/18/70	Bnai Israel	Toms River, N. Jersey

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Bernard Danzansky and Sons 3501-14th St., NW, Wash., DC	OCT 19 1970	B. Tuck D. Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15414 15433

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print): First (DEMETRIOS) JAMES Middle K Last TSAKANIKAS
2a. DATE OF DEATH: Month 10 Day 15 Year 70
2b. HOUR: 5:50 P.M.
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 3/15/87
6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Greece
7b. CITIZEN OF WHAT COUNTRY? U.S.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): VALET SHOP
12b. KIND OF BUSINESS OR INDUSTRY: —
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland 13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 1950 Seminary Rd.
14. FATHER'S NAME First Middle Last: Konstantinos Tsakanikas
15. MOTHER'S MAIDEN NAME First Middle Last: Penelope (UNK)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service): —
16b. SOCIAL SECURITY NO.: 077-16-4621
17. INFORMANT Address: Daughter - Penelope Apostolides - 1950 Sem Rd Silver Sp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: DAYS
1621
DUE TO, OR AS A CONSEQUENCE OF (b): CARCINOMA of LUNG — 1 yr.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC OBSTRUCTIVE PULMONARY DISEASE

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from DEC, 1969, to OCT 15, 1970, that (I) (we) last saw the deceased alive on OCT 15 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/16/70
22d. PHYSICIAN'S NAME (Type): JOEL A. REISKIN, MD
22e. ADDRESS: 50 W. EDMONSTON DR., ROCKVILLE

23a. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 19 NOV. 1970
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
23d. LOCATION (City or Town) (County) (State): SUITLAND MD.
24. FUNERAL DIRECTOR: RINALDI FUNERAL HOME ADDRESS: 7400 GEORGIA AVE. N.W. WASH. DC 20012
25a. REC'D BY REGISTRAR DATE: OCT 19 1970
25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

Cleared by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

2800

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15415

CERTIFICATE OF DEATH

15434

1. DECEASED-NAME (Type or print): First HELEN Middle T. Last VAN DENBERGH
Helen T. VanDenbergh

2a. DATE OF DEATH: Month 10 Day 6 Year 70
2b. HOUR: 6 A.M.

3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 10-4-89
6. AGE (In years last birthday): 81 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN

7a. BIRTHPLACE (State or foreign country): ALBANY, N.Y.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Carriage Hill Nur. Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Fed. Govt.
12b. KIND OF BUSINESS OR INDUSTRY: Treasury Dept.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Washington, D.C.
13b. COUNTY:
13c. CITY OR TOWN: WASH., D.C.
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 4707 Conn. Ave. N.W.

14. FATHER'S NAME First GEORGE Middle M. Last VAN DENBERGH
15. MOTHER'S MAIDEN NAME First JANE Middle — Last TRABER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 217-36-9989
17. INFORMANT: BARBARA C. NICHOLAS
Address: 9129 WALDEN RD. SILVER SPRING, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anaplastic Carcinoma of Lung with Metastases to bone
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.
1621
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Nat while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** thot (I) ~~(this hospital)~~ attended the deceased from June 8, 1970, to October 6, 1970, thot (I) ~~(we)~~ lost sow the deceased olive on October 3 1970, and thot in (my) ~~(our)~~ opinion deoth accurred on the date and hour ond from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body ofter deoth.

22b. SIGNATURE: Robert B. Havell
DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: October 6, 1970

22d. PHYSICIAN'S NAME (Type): Robert B. Havell, M.D
22e. ADDRESS: 5516 Nebraska Ave - DC

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10/9/70
23c. NAME OF CEMETERY OR CREMATORY: OAK HILL CEMETERY
23d. LOCATION (City or Town) (County) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR: JOSEPH GAWLER'S SONS INC.
ADDRESS: 5130 WISC. AVE., N. W. WASH., D. C. 20016

25a. REC'D BY REGISTRAR DATE: OCT 9 1970
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or ottending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1/2

15416

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15435

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Lloyd	H.	Van Kirk, Sr.	10	10	70	11:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
M	W	5/9/86	84 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Pa	U.S.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross	Accountant	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Md	Montgomery	Gaithersburg		2 Russell Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James VanKirk			Susan Miller		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	----------	215 38 5313	Jessie M. VanKirk- wife-	same # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mo
4339
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized atherosclerosis — 4 years
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Urinary tract infection, ASHD & atrial fibrill.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9-14, 19 70, to 10-10, 19 70, that (I) (we) last saw the deceased alive on 10-10-70 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD	☑	☐	☐	10-10-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Abraham W. Danish	1106 Spring St S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/ 13/70	Parklawn Memorial Park	Rockville, Montgomery, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home 1331 Rockville Pike, Rockville, Md.	OCT 15 1970	Bertie D. Rogers

VR A15 (4)
45M - 1/69

0701

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15417 — 15436

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

1. DECEASED-NAME (Type or print)	First: Diane	Middle: Jane	Last: Van Vark	2a. DATE OF DEATH: Month October Day 20 Year 1970	2b. HOUR: 11:15 P
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 2 November 1954	6. AGE (In years last birthday): 15 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Iowa	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery		Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): The Clinical Center, NIH	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Student	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Iowa	13b. COUNTY	13c. CITY OR TOWN: Pella	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 905 Columbus Street	
14. FATHER'S NAME First: Robert	Middle: C.	Last: Van Vark	15. MOTHER'S MAIDEN NAME First: Betty	Middle:	Last: Stevenson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: The Medical Record	Address: The Clinical Center, NIH, Bethesda, Maryland		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary embolus	10 Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Lymphocytic Leukemia	2 Years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Rectal abscess, drug induced leukopenia, Escherichia coli sepsis,

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. I certify thot ☒ (this hospital) attended the deceased from 22 September 1970, to 20 Oct., 1970, that ☒ (we) lost saw the deceased alive an 20 October 1970, and thot in ☒ (our) opinion death accurred on the dote ond hour ond from the couses stated above, ☒ (we) (did) (~~could not~~) view the body after deoth.

22b. SIGNATURE: M. Julian Duttera, Jr. M.D. DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 21 October 1970	
22d. PHYSICIAN'S NAME (Type): M. Julian Duttera, Jr., M.D.	22e. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 10/24/70	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town): OAKWOOD	(County): MARION (State): IOWA
24. FUNERAL DIRECTOR: W. W. CHAMBERS & Co.	ADDRESS: RIVERDALE, MD.	25a. REC'D BY REGISTRAR DATE: OCT 26 1970	25b. REGISTRAR'S SIGNATURE: [signature]	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15418

15437

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
George	E.	Venters	10	23	70	7:04am M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	white	4 7 23	47 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
N. Carolina	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring Md.	Holy Cross Hosp		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montgomery	Rockville	YES ☒ NO ☐	524 Carr Ave

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Claude	E.	Venters	Margaret		Gurganus

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
WW II	'43 - '46	226-22-2581	wife/ Marcene Venters	as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	2 HRS.
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	5 YRS duration
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from April 15, 1965, to October 23, 1970, that (I) (we) last saw the deceased alive on 9/29 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Max Jr. Sherer	MD	☒	☐	☐	10/23/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MAX G. SHERER MD	800 Pershing Drive Silver Spring Md 20910

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Bur. Transit	10/26/70	Greenwood	Greenville, N.S.

24. FUNERAL DIRECTOR ADDRESS	REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home-1391 Rockville Pike Rockville, Maryland	OCT 29 1970	Britt D. Rogers

VR A15 (4) 45M - 1/69

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

15419

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15438

1. DECEASED-NAME (Type or Print) First: John Middle: R. Lost: Viehmann

2a. DATE KNOWN OF DEATH ESTIMATED ☐: Month 10 Day 25 Year 1970

2b. HOUR 6 PM

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: 2-28-1899

6. AGE (In years last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN

2c. DATE PRONOUNCED DEAD Month Oct. Day 25 Year 1970

2d. HOUR 6 40 PM

7a. BIRTHPLACE (State or foreign country): Wash. D.C.

7b. CITIZEN OF WHAT COUNTRY?: U S A

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Wheaton, Md.

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): University Nursing Home

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Govt. Employee

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: D.C.

13b. COUNTY: Wash.

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 3724 Warren St. N.W.

14. FATHER'S NAME First: George Middle: A. Lost: Viehmann

15. MOTHER'S MAIDEN NAME First: Margaret Middle: Fitzgerald Lost:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 579-54-8338T

17. INFORMANT: Ida B. (Wife) ADDRESS: Same As #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Insufficiency Acute. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 min -

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Cardio Vascular Disease — 4 years

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): John G. Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: Oct 25, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 10-28-70

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cem.

23d. LOCATION (City or Town) (County) (State): Washington D.C.

24. FUNERAL DIRECTOR: James E. DeVol ADDRESS: DeVol Funeral Home Inc. 2222 Wisc Ave., N.W. D.C.

25a. REC'D BY REGISTRAR DATE: OCT 30 1970

25b. REGISTRAR'S SIGNATURE: Beatrice D. Rogerson

VR A15ME (5) 10M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15420

CERTIFICATE OF DEATH

15439

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M · 1/69

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year
WALTER	B.	VOGELSANG	10-29-1970

2b. HOUR: 8:42 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	CAUCASIAN	2-1-1900	70 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
New York	U.S.A.	MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross	D.C. Police Dept.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montgomery	Silver Spring	YES ☑ NO ☐	1001 Spring Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Lee		Vogelsang	Katherine		Corcoran

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	216-38-5806	Mrs. Lee E. Vogelsang	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	1/2 hr
DUE TO, OR AS A CONSEQUENCE OF (b)	Pulmonary Insufficiency + ASHD	1 wk
DUE TO, OR AS A CONSEQUENCE OF (c)	Pulmonary Emphysema, Fibrosis, Chronic Bronchitis	

492x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Post-Right Upper Lobectomy (R) Thoracotomy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
10/20/70	Carcinoma RUL lung	YES ☐ NO ☑	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from 10/12, 1970, to 10/29, 1970, that (I) ~~(we)~~ last saw the deceased alive on 10/29 1970, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Marvin L. Kolker	M.D.	☑	☐	☐	10/29/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 2-1970	Gate of Heaven	Silver Spring Montg. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Arthur Walters	254 Carroll St. N.W.	NOV 5 1970	Gordon G. Lindsay

2900

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15421

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15440

1. DECEASED-NAME (Type or Print)	First: BEN[redacted]	Middle: R	Last: WAGNER	2a. DATE KNOWN OF ESTIMATED ☐	Month: 10	Day: 9	Year: 1970
2b. HOUR: 11 A.M.							
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 11/4/1918	6. AGE (In years last birthday): 51 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 10	Day: 9	Year: 1970
2d. HOUR: 1 A.M.							
7a. BIRTHPLACE (State or foreign country): North Car.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.				
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 12001 Remington Drive	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Plasterer	12b. KIND OF BUSINESS OR INDUSTRY: Same				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Mont.	13c. CITY OR TOWN: Sil. Spr.	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 12001 Remington Drive			
14. FATHER'S NAME First: Isaac	Middle: Glenn	Last: Wagner	15. MOTHER'S MAIDEN NAME First: Cordelia	Middle:	Last: Kloniger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): W.W. II	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Robert L. Wagner, (son) 7956 Lakecrest				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Exsanguination due to

DUE TO, OR AS A CONSEQUENCE OF (b) gastrointestinal hemorrhage,

DUE TO, OR AS A CONSEQUENCE OF (c) etiology unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5699

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Obesity

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Leap M.D.

EXAMINER'S NAME (Type): BELDEN R. LEAP, M.D. ADDRESS (Street, city, town, or county): Silver Spring

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: Oct. 9, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 13. 1970	Fort Lincoln Cemetery	Colmar Manor P.G. Md

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Takoma Funeral Home J.A. Walters, 254 Carroll St NW. DC	OCT 13 1970	Bettie D. Rogers

VR A15ME (5) 10M REV. 1/68

3208

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

15422

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15442

1. DECEASED-NAME (Type or Print): First Blanche Middle L Last Walker

2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☒ Month 10 Day 26 Year 1970

2b. HOUR 5:45 PM

3. SEX: Fe

4. RACE: Negro

5. DATE OF BIRTH: Nov 8-24

6. AGE (In years last birthday): 55 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS: HOURS / MIN.

2c. DATE PRONOUNCED DEAD Month Oct Day 26 Year 1970

2d. HOUR 5:45 PM

7a. BIRTHPLACE (State or foreign country)

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 2619 Colston Dr

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Washington 13b. COUNTY: D.C.

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 1438 Meridan PL

14. FATHER'S NAME First JOHN Middle L Last LOMAX

15. MOTHER'S MAIDEN NAME First PEARL Middle Last CUNNINGHAM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.

17. INFORMANT: EVA S. BROOK ADDRESS: 1438 Meridan

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Insufficiency Acute

DUE TO, OR AS A CONSEQUENCE OF

(b) Cardio Vascular Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4124

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden. / years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S Ball M.D.

EXAMINER'S NAME (Type): Watson Funeral Home

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: Oct 26, 1970.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10/31/70

23c. NAME OF CEMETERY OR CREMATORY: HARMONY

23d. LOCATION (City or Town) (County) (State): LANDOVER RD MD

24. FUNERAL DIRECTOR: John D. Watson ADDRESS: 3435 14th St N.W.

25a. REC'D BY REGISTRAR DATE NOV 2 1970

25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible]. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

VR A15ME (S)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15423 — 15443

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: FRANK	Middle: EDWARD	Last: WALKER	2a. DATE OF DEATH Month: 10 Day: 30 Year: 70	2b. HOUR: 7:30 P.M.	
3. SEX: M.	4. RACE: CAUC.	5. DATE OF BIRTH: 5/27/12	6. AGE (In years last birthday): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.			
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Bus Driver	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Cabin John	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 23 Ericson Road		
14. FATHER'S NAME First: Frank	Middle: Benjamin	Last: Walker	15. MOTHER'S MAIDEN NAME First: Sarah	Middle:	Last: Stacks	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 579 03 5094	17. INFORMANT: Wife Mildred Walker	Address: 23 Ericson Rd. Cabin John, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1m
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Acute Myocardial Infarct — 2 days
DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Arteriosclerosis — 10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Jan, 1967, to Oct 20, 1970, that (I) (we) last saw the deceased alive on Oct 20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William Henry Killay	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: Oct 21 1970	
22d. PHYSICIAN'S NAME (Type): William Henry Killay	22e. ADDRESS: 8218 Wisconsin Ave Bethesda		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/23/70	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park	23d. LOCATION (City or Town) (County) (State): Rockville, Maryland	
24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home	ADDRESS: 1331 Rockville Pike, Rockville, Md.	25a. RECD BY REGISTRAR DATE: OCT 26 1970	25b. REGISTRAR'S SIGNATURE: Willie S. Rogers	

VR A15 (4)
45M - 1/69

9 1

15424

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15444

1. DECEASED-NAME (Type or print) First: MARY Middle: E. Last: WALTER	2a. DATE OF DEATH Month: October Day: 6 Year: 1970	2b. HOUR: 6 P.M.	
3. SEX: Fe	4. RACE: Caucasian	5. DATE OF BIRTH: October 4, 1933	6. AGE (In years last birthday): 37 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Potomac Valley Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.): Binder Worker	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montg.	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 914 Maple Ave			
14. FATHER'S NAME First Middle Last: Walter R. Cornwell	15. MOTHER'S MAIDEN NAME First Middle Last: Virgie Abell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service): ---	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: Carol A. Walter-same # 13 (Daughter)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of cervix c̄ metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 MOS

180X

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 5/26/70, 19___, to 10/6/70 19___, that (I) (we) last saw the deceased alive on 10/6/70 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry C. Scruggs MD	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/6/70	
22d. PHYSICIAN'S NAME (Type): Henry C. Scruggs MD	22e. ADDRESS: 5413 Cedar Lane Bethesda Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/8/70	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park	23d. LOCATION (City or Town) (County) (State): Rockville, Maryland
24. FUNERAL DIRECTOR: Tyson Wheller Funeral Home	ADDRESS: 1331 Rock. Pike Rockville, Maryland	25a. REC'D BY REGISTRAR DATE: OCT 9 1970	25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1101

Item 22a Film 430
11/2/70 mh

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

15425

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15446

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN ☒ OF DEATH ESTIMATED ☐ Month	Day	Year	2b. HOUR	
MEARL	G.	WAREHIME	10-	18	1970	4:10 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
MALE	Cau.	9-19-07	63 YRS.			Oct	18	1970	4:45 P.M.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH				
MARYLAND	U.S.A.		Montgomery Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda	Suburban	FARMER	Hospital				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER			
Md	Montgomery	Germantown		Box 101			
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last		
FOSTER	WAREHIME		MINNIE		BENDICT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS				
NO	217-12-1741	MRS MEARL WAREHIME	GERMANTOWN MD.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple Injuries Severe -	5hr.
DUE TO, OR AS A CONSEQUENCE OF		
(b)	Trauma from Auto Accident	5hr.
DUE TO, OR AS A CONSEQUENCE OF		
(c)	Cerebral Hemorrhage -	5hr

8199

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	1:53 P.M. 10/17 1970	Had stroke & was struck by car.

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Highway	Route 118 & 355	Gaithersburg	Montg.	Md.

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) John G. Bell M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED Oct 18, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/21/70	ROCKY HILL	NR. WOODSBORO, FRED., MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BARTON FUNERAL HOME, WALKERSVILLE, MD.	21793	OCT 21 1970	Burtie D. Rogers

VR A15ME (5) 10M - 1/69

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15426

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15447

1. DECEASED-NAME (Type or print) First: William H. Middle: Weaver Last:	2a. DATE OF DEATH Month: 10 Day: 3 Year: 70	2b. HOUR: 1:30 P.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 8-15-28	6. AGE (In years last birthday): 42 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Wash D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): ASST MGR - County	12b. KIND OF BUSINESS OR INDUSTRY: ABC Board
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Mont.	13c. CITY OR TOWN: Chevy Chase	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER: 5501 Park Street
14. FATHER'S NAME First: Charles Middle: Weaver Last:	15. MOTHER'S MAIDEN NAME First: Edna Middle: Haimes Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 216-22-0005	17. INFORMANT: Wife Irene Address: Same	AS# 13-AB-C-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ruptured Esophageal Varix — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hr

5719

DUE TO, OR AS A CONSEQUENCE OF (b): Cirrhosis of Liver — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (~~this hospital~~) attended the deceased from May, 1968, to 10-3, 1970, that (I) (~~we~~) last saw the deceased alive on 10/2 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Frank Y Jaggers Jr MD DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-4-70	
22d. PHYSICIAN'S NAME (Type): FRANK Y. JAGGERS JR MD	22e. ADDRESS: 5707 WISCONSIN AVE Chevy Chase, Md 20015		
23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION	23b. DATE: OCT 6/1970	23c. NAME OF ~~CEMETERY OR~~ CREMATORY: CEDAR HILL CREMATORY	23d. LOCATION (City or Town) (County) (State): SUITLAND RD, Pr Geo Co, MD.
24. FUNERAL DIRECTOR: JOSEPH GAWLER'S SONS INC. ADDRESS: 5130 WISC. AVE. N. W. WASH. D. C. 20016	25a. REC'D BY REGISTRAR DATE: OCT 7 1970	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

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15427

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15448

1. DECEASED-NAME (Type or print) First: ELSIE Middle: E. Last: WENZEL	2a. DATE OF DEATH Month: October Day: 21 Year: 1970	2b. HOUR: 12A M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH: 7-30-1890	6. AGE (In years last birthday): 80XXX YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY Md.
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): University Nurs Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Private Nurse	12b. KIND OF BUSINESS OR INDUSTRY: Nursing
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: Washington D C	13b. COUNTY: -------	13c. CITY OR TOWN: Wash DC	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 4007 Conn Ave NW			
14. FATHER'S NAME First: JOHN Middle: Last: WENZEL	15. MOTHER'S MAIDEN NAME First: PAULINE Middle: Last: RATKEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes NO (or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 577-68-7286	17. INFORMANT Address: Mary E.Ennis;Rte 6,Box 126,Falmouth VA	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

5990

IMMEDIATE CAUSE (a) Septicemia

DUE TO, OR AS A CONSEQUENCE OF

(b) Genito Urinary tract infection

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CVA c right hemoplegia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 6-26, 1970, to Oct 21, 1970, that (I) (we) last saw the deceased alive on _____ 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joel A. Reiskin MD	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type): JOEL A. REISKIN, MD	22e. ADDRESS: 50 W. EDMONSTON DR, ROCKVILLE		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 24 Oct 1970	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State): Colmar Manor PRINCE GEORGES MD.
24. FUNERAL DIRECTOR: W.W.Chambers Co.	ADDRESS: Riverdale,Md.	25a. REC'D BY REGISTRAR DATE: OCT 26 1970	25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M · 1/69

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FOR STATE HEALTH DEPT.

15428

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15449

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MD3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: Carolyn	Middle: T.	Last: Wheeler	2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month: 10 Day: 15 Year: 1970		2b. HOUR: 2 PM
3. SEX: Fe	4. RACE: White	5. DATE OF BIRTH: 9-5-1951	6. AGE (In years last birthday): 19 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 10 Day 15 Year 1970		2d. HOUR: 2 PM
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.			
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Student	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 10620 Weymouth St.		
14. FATHER'S NAME First: Ralph	Middle: H.	Last: Wheeler, Jr.	15. MOTHER'S MAIDEN NAME First: Tyrrell	Middle: H.	Last: Nester	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Father	ADDRESS: Ralph H. Wheeler, Jr. Same			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Injuries, multiple, severe — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hr

DUE TO, OR AS A CONSEQUENCE OF

(b): Automobile accident

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

8161

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10:30 AM Oct 15 1970	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in car went out of control	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Battery	21f. LOCATION Street or R.F.D. No. Route 495 + Linden Lane	City or Town: Silver Spring	County: Montgomery	State: Md.

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): JOHN G. BALL, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Bethesda, Md.

22b. DATE SIGNED: Oct. 16, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	10-17-70	Cedar Hill Crematory	Suitland, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey, P.A.,	Bethesda, Md.	OCT 22 1970	Bertie D. Rogers

VR A15ME (5) 10M - 1/69

1203

15429

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15450

1. DECEASED-NAME (Type or print): First Joseph; Middle Roy; Last Whipp
2a. DATE OF DEATH: Month 10; Day 25; Year 70
2b. HOUR: M
3. SEX: Male
4. RACE: Caus.
5. DATE OF BIRTH: 12/11/1909
6. AGE (In years last birthday): 60 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Md
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Montg. Md.
10. CITY OR TOWN OF DEATH: Clarksburg
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Gasoline & Garage Sta. Owner
12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Montg.
13c. CITY OR TOWN: Clarksburg
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER
14. FATHER'S NAME: First Stanley; Middle Whipp; Last
15. MOTHER'S MAIDEN NAME: First Ella; Middle Edwards; Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 220-32-6878
17. INFORMANT: Inez R. Whipp; Address: Clarksburg Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4109 IMMEDIATE CAUSE (a) Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hour
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis — 2 years
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION: Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10/31, 1966, to 10/25, 1970, that (I) (we) last saw the deceased alive on 10/23 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James B. Thomas — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 10/26/70
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/28/70
23c. NAME OF CEMETERY OR CREMATORY: Clarksburg Methodist
23d. LOCATION (City or Town) (County) (State): Clarksburg Montg Md
24. FUNERAL DIRECTOR: Constance C. Hilton; ADDRESS: Barnesville Md
25a. REC'D BY REGISTRAR: DATE OCT 30 1970
25b. REGISTRAR'S SIGNATURE: Bettie J. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 45M - 1/69

0302

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15430

CERTIFICATE OF DEATH

15451

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
DOROTHY	MARIE	WHITE	OCTOBER	3	1970	9:25 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
FEMALE	CAUC.	October 14th, 1900	69 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Missouri	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Chevy Chase	4707 Chevy Chase Drive	Housewife	At home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Chevy Chase	YES [X] NO [ ]	4707 Chevy Chase Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John		Williamson	Marie		Martinson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	245-16-4324	William B. White, 4707 Chevy Chase Drive,	Chevy Chase, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4379

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 hrs. / ? /

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from ——, 19 60, to 10-3, 19 70, that (I) ~~(we)~~ last saw the deceased alive on 10-3 19 70, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Thomas H. Gray Jr. MD	MD	[X]	[ ]	[ ]	10/3/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Thos. H. GRAY JR MD	4140 Chevy Chase Drive Chevy Chase, Md. 20015

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 6th, 1970	Arlington Nat'l Cemetery	Arlington, Virginia

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH GAWLER'S SONS INC.	5130 WISC. AVE., N. W. WASH. D. C. 20016	OCT 7 1970	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

4802

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15431

15452

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Paul	Middle: E.	Last: White	2a. DATE OF DEATH Month: Oct	Day: 27	Year: 1970	2b. HOUR: 10:39 A M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: 4/3/1905	6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.				
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carriage Hill Extended Care Facility	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Lab technician	12b. KIND OF BUSINESS OR INDUSTRY: Harry Diamond Lab.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 4400 East-West Highway			
14. FATHER'S NAME First: Lewis	Middle: E.	Last: White	15. MOTHER'S MAIDEN NAME First: Roszella	Middle: Mae	Last: Browning		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-10-2841-A	17. INFORMANT: Carriage Hill Nursing Home Records	Address				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 90 days

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): Bronchogenic Carcinoma — 12 mos.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Oct, 1969, to Oct, 1970, that (I) ~~(we)~~ last saw the deceased alive on Oct 24 1970, and that in (my) ~~(our)~~ apinian death accurred on the date and haur and from the causes stated abave, (I) ~~(we)~~ (did) (~~did not~~) view the bady after death.

22b. SIGNATURE: John D Herman M.D.	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]
22c. DATE SIGNED: Oct 27, 1970				
22d. PHYSICIAN'S NAME (Type): John D. Herman	22e. ADDRESS: 4801 Montgomery Ln Bethesda, Md			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 29, 1970	23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery	23d. LOCATION (City or Town): Frederick	(County): Frederick	(State): Md
24. FUNERAL DIRECTOR: M. R. Etchison & Son, Frederick, Md.	ADDRESS: Frederick	25a. REC'D BY REGISTRAR DATE: OCT 29 1970	25b. REGISTRAR'S SIGNATURE		

VR A15 (4) 45M - 1/69

4802

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 2 15432 — 15453

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: KEMP	Middle: FOWLER	Last: WHITESIDE	2a. DATE OF DEATH: Month Oct. Day 9 Year 70 — 2b. HOUR: 1230 A M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: Sept. 25 1962	6. AGE (In years last birthday): 8 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): N/A	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 4502 Delmont Lane
14. FATHER'S NAME First: Daniel	Middle: F.	Last: Whiteside	15. MOTHER'S MAIDEN NAME First: Patricia	Middle: Littleton	Last: Whiteside
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: N/A	17. INFORMANT: Daniel F. Whiteside	Address: Bethesda, Md. 4502 Delmont La.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cystic Fibrosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: since birth

2730

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceosed from Oct. 2, 1970, to Oct. 9, 1970, thot (I) (we) last saw the deceased alive an Oct. 9 1970 and that in (my) (aur) apinian death accurred on the dote ond hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Melvin Musseles — DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: Oct. 9, 1970	
22d. PHYSICIAN'S NAME (Type): Melvin Musseles	22e. ADDRESS: Naval Hospital, Bethesda, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-12-70	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State): Rockville Montgomery Md	
24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home	ADDRESS: 7557 Wisconsin Ave., Bethesda, Md.	25a. REC'D BY REGISTRAR DATE: OCT 15 1970	25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers	

VR A15 (4) 25m-1/70

H100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15433 — 15454

1. DECEASED-NAME (Type or print): First ELBERT; Middle C.; Last WICKS
2a. DATE OF DEATH: Month 10; Day 19; Year 70
2b. HOUR: 8 10 A M
3. SEX: MALE
4. RACE: CAU.
5. DATE OF BIRTH: 3/22/1889
6. AGE (In years last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): NEW YORK
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: MONTGOMERY Md.
10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): GROSVENOR LANE NSG & CONV. CENTER
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): DELIVERYMAN
12b. KIND OF BUSINESS OR INDUSTRY: —
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: WEST HYATTSVILLE
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 7021 HIGHVIEW TERRACE
14. FATHER'S NAME First JESSIE; Middle —; Last WICKS
15. MOTHER'S MAIDEN NAME First Emma; Middle —; Last COOPER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): 1918-1919
16b. SOCIAL SECURITY NO.: 103-18-1400
17. INFORMANT: Address: Ethel Wicks 7021 Highview Tr. W. Hy. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 MIN
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC VASCULAR DISEASE — 5 MO
DUE TO, OR AS A CONSEQUENCE OF
(c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4409

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 6/20, 19 70, to 19 OCT, 19 70, that (I) ~~(we)~~ last saw the deceased alive on 10/9 19 70, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: Walter E. Gooth MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 10/19/70

22d. PHYSICIAN'S NAME (Type): WALTER E. GOOTH MD — 22e. ADDRESS: 2309 SHOREFIELD RD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE: 10-22-70 — 23c. NAME OF CEMETERY OR CREMATORY: GREENFIELD CEM. — 23d. LOCATION (City or Town) (County) (State): HEMPSTEAD L.I. NEW YORK

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, P.A. BETHESDA, Md. — 25a. REC'D BY REGISTRAR DATE: OCT 22 1970 — 25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15434

15455

1. DECEASED-NAME (Type or print): First: Frances; Middle: C.; Last: WIDGER

2a. DATE OF DEATH: Month: Oct; Day: 30; Year: 1970

2b. HOUR: 5.50 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: 10-14-93

6. AGE (In years last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN

7a. BIRTHPLACE (State or foreign country): Illinois

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Kensington

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Kensington Gardens

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Mont.

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET AND NUMBER: 4526 Amherst Lane

14. FATHER'S NAME First: John; Middle: ; Last: McCabe

15. MOTHER'S MAIDEN NAME First: Rose; Middle: ; Last: Daly

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.:

17. INFORMANT: Vincent J. Esworthy Address: Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest (Expended Pacemaker)
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic H.D.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATN (If either, notify medicol examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from Aug, 1969, to Oct 30, 1970, that (I) (~~we~~) last saw the deceased alive on Oct 22 1970, and that to (my) (~~our~~) opinion death occurred on the date and haur and from the causes stated above. (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: R Thibadeau M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: Oct 30-70

22d. PHYSICIAN'S NAME (Type): Robert T. Thibadeau, M.D.

22e. ADDRESS: 11000 Old Georgetown Rd., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11-2-70

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Suitland, Md.

24. FUNERAL DIRECTOR: Francis J. Collins ADDRESS: 500 University Blvd. W., Silver Spring, Md.

25a. REC'D BY REGISTRAR · DATE: NOV 2 1970

25b. REGISTRAR'S SIGNATURE: Burrid. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

4300

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (3)
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15435 — 15456

1. DECEASED-NAME (Type or print)	First	Middle	Last: WILSON	2a. DATE OF DEATH: Month October, Day 30, Year 1970	2b. HOUR: 2:45 P.M.	
3. SEX: FEMALE	4. RACE: White	5. DATE OF BIRTH: Oct 14, 1970	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR: MONTHS, DAYS: 16	IF UNDER 24 HRS.: HOURS, MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Holy Cross	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgom.	13c. CITY OR TOWN: GERMANTOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RT #1 Box 247		
14. FATHER'S NAME First: Charles	Middle: T.	Last: Wilson	15. MOTHER'S MAIDEN NAME First: Judith	Middle: May	Last: Whalen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: Father	Address: as above			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Severe Congenital Anomalies — 740X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): Anencephaly

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospitol) attended the deceased from October 14, 1970, to October 30, 1970, that (I) (we) last saw the deceased olive an October 30, 1970, and thot in (my) (our) apinion death accurred on the dote ond hour and from the causes stoted above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Protacio A. Reyes, M.D.	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/30/70		
22d. PHYSICIAN'S NAME (Type): PROTACIO A. REYES	22e. ADDRESS: 431 N. Frederick Ave. Gaithersburg			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/3/70	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION (City or Town): Silver Spring,	(County) Md. (State)
24. FUNERAL DIRECTOR: 1331 Rockville Pike	ADDRESS: Rockville, Maryland	25a. REC'D BY REGISTRAR DATE: NOV 5 1970	25b. REGISTRAR'S SIGNATURE: Vernon F. Randall	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15436 — 15457

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removol, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: FLORENCE	Middle: E	Last: WILSON	2a. DATE OF DEATH Month: OCT. Day: 30 Year: 70	2b. HOUR: 5:20 P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 4-30-80	6. AGE (In years last birthday): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): England	7b. CITIZEN OF WHAT COUNTRY?: U.S.	B. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Mgr. Pt-y Cleaning Co.	12b. KIND OF BUSINESS OR INDUSTRY: Mant. Ret		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 9004 Manchester Rd.	
14. FATHER'S NAME First: John	Middle:	Last: Foster	15. MOTHER'S MAIDEN NAME First: Unknown	Middle:	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 579-30-0677A	17. INFORMANT: Mrs Mona Engler	Address: 9004 Manchester Rd Silver Spring Md		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease — years
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Ht. Disease — 4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Adenocarcinoma of Rectum.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot (I) (this hospitol) ottended the deceased from _____, 19 60, to 10/30, 19 70, that (I) (~~we~~) last sow the deceased olive on 10/30 19 70, and thot in (my) (~~our~~) opinion death occurred on the dote and hour ond from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body ofter death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
G. Leonard Rod M					10/31/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
	7801 Ga. Ave. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/3/70	Fort Lincoln Cem	Bladensburg Rd. Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W. W. Chambers Co.	200 Georgia Ave Silver Spring	NOV 4 1970	Vernon B. Randall

2302 VR A15 (4) 45M - 1/69

Items 18, 21a to 21f, 22a
Film 429 10/21/70 mh

FOR STATE HEALTH DEPT.

15437

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15458

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DHS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Theodore	Middle: RAYMOND	Last: Wilson	2a. DATE OF DEATH KNOWN ☒ / ESTIMATED ☐ Month: Oct	Day: 3	Year: 1970	2b. HOUR: 6:55 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7-17-31	6. AGE (In years last birthday): 39 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: Oct	Day: 3	Year: 1970	2d. HOUR: 7:40 P.M.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery. Md.				
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Economist	12b. KIND OF BUSINESS OR INDUSTRY: Health Research				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 6107 Greentree Rd.			
14. FATHER'S NAME First: W.	Middle: Raymond	Last: Wilson	15. MOTHER'S MAIDEN NAME First: Hilda	Middle:	Last: Nolte.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 219-28-0365	17. INFORMANT: wife B. Wilson	ADDRESS: Same				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 9509 Cyanide Poisoning
DUE TO, OR AS A CONSEQUENCE OF
(b): Ingestion of Cyanide
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6:30 P.M. 10/3/1970	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Took large dose of cyanide
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home	21f. LOCATION Street or R.F.D. No.: 6107 Greentree Rd. City or Town: Bethesda, Mont. County: Md. State:

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Ball M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: Oct 4, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: Oct 6, 1970	23c. NAME OF CEMETERY OR CREMATORY: PLEASANT GROVE CEM.	23d. LOCATION (City or Town) (County) (State): PLEASANT GROVE BALT. MD.	
24. FUNERAL DIRECTOR: RAYMOND J CURRAN	ADDRESS: 817 SCARLETT PL TOWSON, MD. 21204	25a. REC'D BY REGISTRAR DATE: OCT 8 1970	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15ME (5) 10M - 1/69

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15438

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15459

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MAE	CROSBY	WISER	10	18	70	1000 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	2/6/10	60 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. Virginia	USA	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban	housewife	At Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montgomery	Chevy Chase	YES ☒ NO ☐	3509 Shepherd Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	E.	Crosby	Mary	—	Marks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (HUSBAND)	Address
No		Ralph L. Wiser	3509 Shepherd St. Chevy Chase, Md.

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinoma of Pancreas — 6 mo

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) ([redacted]) attended the deceased from June, 1970, to Oct 18, 1970, that (I) (~~we~~) last saw the deceased alive an Oct 16 1970, and that in (my) ([redacted]) opinian death accurred an the date and haur and fram the causes stated above, (I) ([redacted]) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
James W Egan		☒	☐	☐	10/19/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JAMES W. EGAN	5413 CEDAR LA. BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/22/70	ARLINGTON NAT. CEM.	ARLINGTON, VA.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH GAWLER'S SONS INC. 5130 WISC. AVE. N.W. WASH. D.C. 20016	OCT 26 1970	Bettie D. Rogers

VR A15 (4) 45M - 1/69

$200

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15439

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15460

1. DECEASED-NAME (Type or print) First: X Mary Middle: Last: Woody	2a. DATE OF DEATH Month: 10 Day: 19 Year: 1970	2b. HOUR: 1:05 P M	
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH: 1/22/1884	6. AGE (In years last birthday): 86 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): unknown	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): University Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Wash. DC	13b. COUNTY	13c. CITY OR TOWN: Wash. DC	13d. INSIDE CITY LIMITS? YES XX NO ☐ 13e. STREET AND NUMBER: 1330 Ft. Stevens Drive
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 578-12-3869	17. INFORMANT Address	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

1541

IMMEDIATE CAUSE (a) Terminal Ca of Rectum — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mo.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/6, 1970, to 10/19, 1970, that (I) (we) last saw the deceased alive on 10/19 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joel A. Reiskin MD	DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 10/19
22d. PHYSICIAN'S NAME (Type): JOEL A. REISKIN, MD	22e. ADDRESS: 50 W. EDMONSTON DR., ROCKVILLE	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 10-25-70	23c. NAME OF CEMETERY OR CREMATORY: Harmony
23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR: W. H. Bacon	ADDRESS	25a. REC'D BY REGISTRAR DATE: OCT 21 1970
25b. REGISTRAR'S SIGNATURE: Bettie J. Rogers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15440 — 15461

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: AMALIA	Middle: D	Last: Yasbec	2a. DATE OF DEATH: Month Oct, Day 13, Year 1970		2b. HOUR: 11:20 A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 6/5/87	6. AGE (In years last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Yougoslavia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY			Md.
10. CITY OR TOWN OF DEATH: Kensington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Kensington Gardens Sanit	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House wife	12b. KIND OF BUSINESS OR INDUSTRY: At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Takoma Park	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 7417 Birch Ave		
14. FATHER'S NAME First: UNKNOWN	Middle	Last	15. MOTHER'S MAIDEN NAME First: UNKNOWN	Middle	Last: Dobrovec	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service): None	16b. SOCIAL SECURITY NO.: 350-01 4400 P	17. INFORMANT: Joseph F. Yasbec (Son)	Address: 7417 Birch Ave, Takoma Park, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: month
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic heart disease — year.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus, Q Unjection.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
Accident 9/4/70 - fall / Cleared w medical examiner Dr Reap 10/13/70			
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 1968, to 10/13, 1970, that (I) (we) last saw the deceased alive on 10/8 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Israel Spector MD		☒	☐	☐	10/13/70
22d. PHYSICIAN'S NAME (Type): Israel Spector M.D.		22e. ADDRESS: 911 Silver Spring Ave SS Md 20910			

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
	10/16/70	Ft. Lincoln Cem.	Bladensburg Rd.	P.G.	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W.W. Chambers Co	8655 Ga. Ave. Sil. Spring Md	OCT 19 1970	Bettie D. Rogers

VR A1514
25m-1/70

Cleared with Dr Reap. Coroner

1800

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15441

CERTIFICATE OF DEATH

15462

1. DECEASED-NAME (Type or print): First GERTRUDE Middle RITA Last ZIMMER

2a. DATE OF DEATH: Month Oct. Day 7. 1970 Year

2b. HOUR: 3:44 M

3. SEX: Female

4. RACE: Cauc.

5. DATE OF BIRTH: July 3, 1903

6. AGE (In years last birthday): 67 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN

7a. BIRTHPLACE (State or foreign country): Mass.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 10401 Grosvenor Pl.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Buyer-Women's Apparel

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 10401 Grosvenor Place

14. FATHER'S NAME First Middle Last: Hargrap Aaronian

15. MOTHER'S MAIDEN NAME First Middle Last: Marion (Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16b. SOCIAL SECURITY NO. (If yes give war or dates of service):

17. INFORMANT: husband Harry J. Zimmer Address: Same as Item 13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: HOURS
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE YRS
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC-BRONCHITIS, EMPHYSEMA YRS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from FALL, 1964, to OCT. 4, 1970, that (I) (we) last saw the deceased alive on SEPT. 15 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Albert H. Grollman DEGREE: MD ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 10/6/70

22d. PHYSICIAN'S NAME (Type): ALBERT H. GROLLMAN MD

22e. ADDRESS: 1106 SIXTH ST. SILVER SPRING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10-6-70

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.

23d. LOCATION (City or Town) (County) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, P.A., Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: OCT 7 1970

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15442 15463

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LEONARD	JAMES	ZYGMONT	October 23, 1970	11:25 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	November 1, 1910	59 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A. America	MARRIED X	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington Sanitarium	Compositor--Washington Post	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Silver Spring	YES X NO	11703 Goodlow Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John		Zygmont	Martha		Wolski

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	218-18-9734	Patient's chart

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic lung cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
1970
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES NO X	

21a. ACCIDENT WAS / DR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 10/14, 19 70, to 10/23, 19 70, that (I) (we) last saw the deceased alive on 10/23, 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Lewis Hilliard Dennis	MD	X			10/24/70

22d. PHYSICIAN'S NAME (Type) Lewis Hilliard Dennis MD
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-27-70	Gate of Heaven	Silver Spring, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis J. Collins 500 University Blvd. W., Silver Spring, Md.	OCT 28 1970	Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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